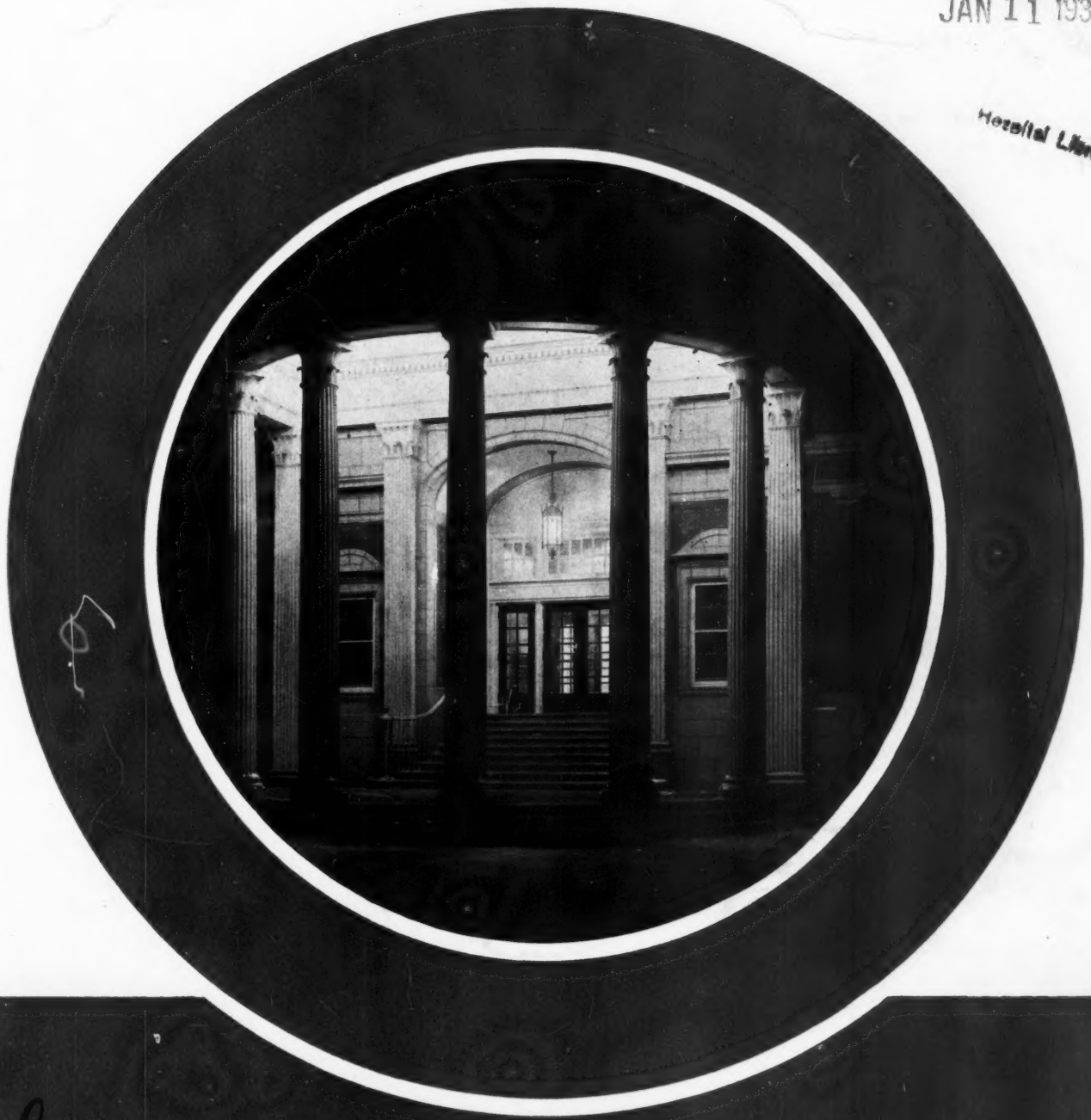


JAN 11 1937

Hospital Library

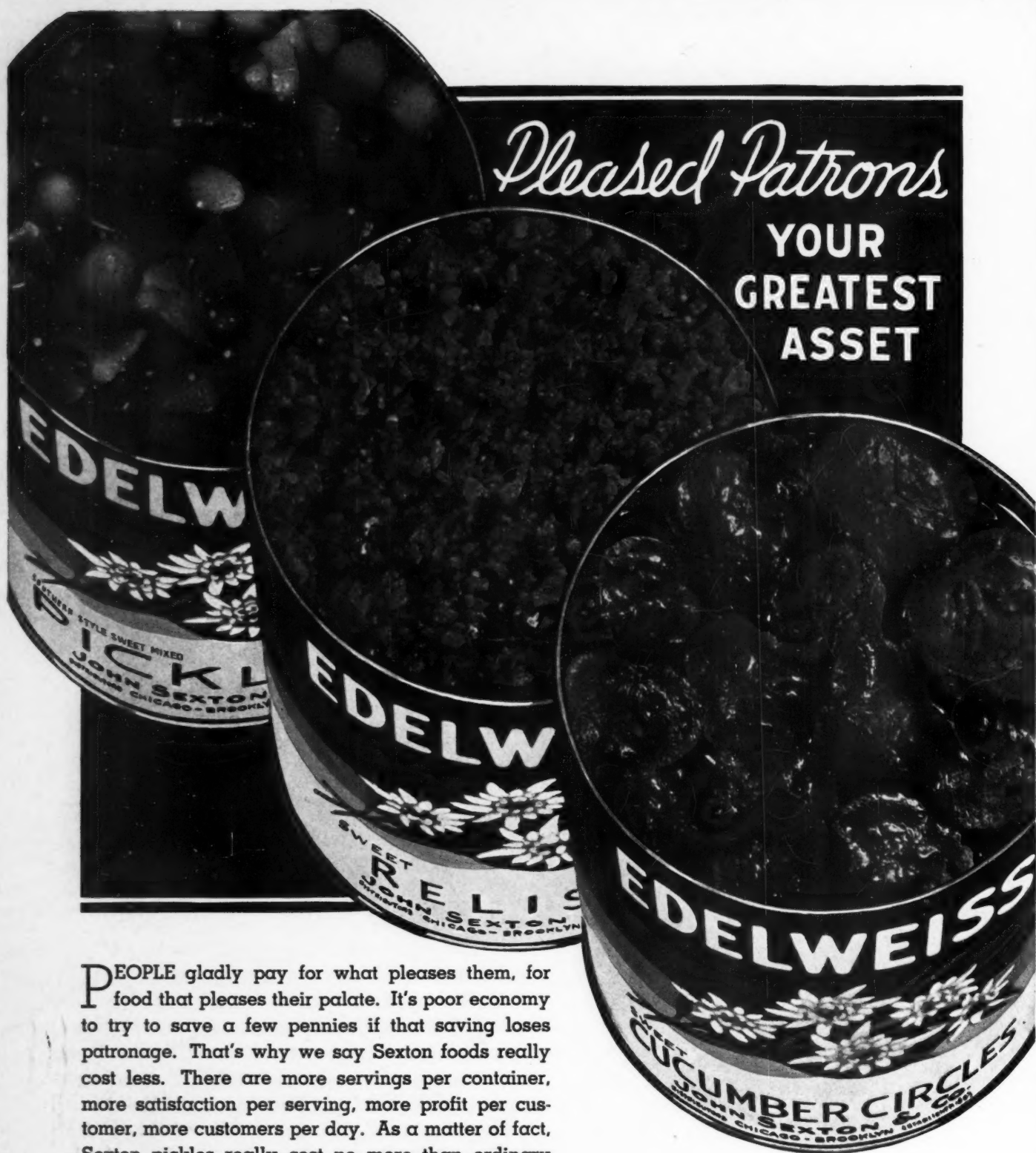


the
MODERN
HOSPITAL

VOLUME 3

JANUARY 1937

NUMBER 1



Pleased Patrons

**YOUR
GREATEST
ASSET**

PEOPLE gladly pay for what pleases them, for food that pleases their palate. It's poor economy to try to save a few pennies if that saving loses patronage. That's why we say Sexton foods really cost less. There are more servings per container, more satisfaction per serving, more profit per customer, more customers per day. As a matter of fact, Sexton pickles really cost no more than ordinary pickles. We make every saving possible, by most careful selection, beginning with the seed. We grade them ourselves and process them in our own Sunshine Kitchens. Your pleased patrons are also our greatest asset and we guard it zealously.

Sexton Specials offer outstanding values in foods prepared exclusively for those who feed many people each day.

JOHN SEXTON & CO.

CHICAGO

Manufacturing Wholesale Grocers

BROOKLYN

Established 1883
America's Largest Distributors of No. 10 Canned Foods

CONTENTS

For January, 1937

Just in Passing—

Cover Page—Albany Hospital, Albany, N. Y. Berlin & Swern, Chicago, Architects.	
Looking Forward	41
The percentage of hospital occupancy is increasing, say THE EDITORS who also editorialize on hospital-made static, the nurse anesthetist, the international hospital association, and staff selfishness. A tribute is paid to the late Doctor Sexton.	
Next Objectives	44
Four outstanding goals for hospitals are suggested by SURGEON-GENERAL THOMAS PARRAN of the U. S. Public Health Service: wider use of facilities, improved facilities, studies of hospital data and cooperation with public health agencies.	
Five Life-Saving Stations in the North Woods.....	46
Hospital care in the Iron Range of Wisconsin and Minnesota, described by ALDEN B. MILLS, managing editor.	
Administrative Case Histories.....	53
J. B. HOWLAND, M.D., and N. A. WILHELM, M.D., superintendent and assistant superintendent of Peter Bent Brigham Hospital, Boston, carry on the case history series, throwing light on four problems—admitting patients, emergency patients, care of valuables and clothes, and what information about patients may be given and to whom.	
On a Roman Hill.....	57
Stands the Ospedale del Littorio, a consolidation of several old and and glorious institutions, described by NATALE COLOSI, general director of Parkway Hospital, New York City.	
Associations Set 1937 Tasks.....	59
The presidents of national associations connected with the hospital fields outline their objectives for the new year.	
Modernization Step by Step.....	64
Has been found by Presbyterian Hospital, Chicago, to be an efficient and economical way to remodel an old building.	
What's Next?	65
A tale of gloom, written by JOHN H. HAYES, superintendent of Lenox Hill Hospital, New York City, one day when he apparently had a fit of blues.	
The Premature Baby.....	67
In Chicago is ensured good care through the requirements and recommendations of the Chicago Board of Health, whose president, HERMAN N. BUNDESEN, M.D., describes the city's hospital facilities for premature infants.	
From Rochester to Stockholm.....	72
A pictorial presentation of the Eastman Dental Clinic, Stockholm, Sweden.	
Many "Musts" for an Intern.....	74
If he would have success, according to GEORGE T. KERSEY, M.D., Provident Hospital, Chicago.	

MODERN hospital practice relies heavily upon disinfection and sterilization. Yet many of the methods followed, even by leading hospitals, have not been subjected to critical analysis and review. There is great diversity of technique and some of the methods do not provide adequate safety. On the other hand, many hospitals in their zeal to assure absolute sterility have set up procedures that are so prolonged or violent that their goods and supplies suffer unnecessary deterioration. Safety must be assured but it should not be necessary to weaken or destroy rubber gloves, dressings and other sterilized supplies in the process.

To discover the most effective and best methods of sterilization and disinfection, a cooperative study has been carried on for several years at the University Hospitals of Cleveland. Under the general guidance of Dr. Howard T. Karsner, director of pathology, Dr. E. E. Ecker and his associates have established controlled and adequate methods of sterilization and disinfection for the whole hospital. Doctor Ecker has put the results of his studies into five papers, which will be published as a series in THE MODERN HOSPITAL. The first of them will appear next month.

THE new specialty examining boards are setting standards for postgraduate training that will affect all hospital residencies. Furthermore hospitals will soon have an opportunity to choose their departmental chiefs on the basis of an objective estimate of qualifications. All this should mean better preparation for the practice of the specialties and better control over that practice. Next month Dr. Willard C. Rappleye, dean of the College of Physicians and Sur-

Published monthly by The Modern Hospital Publishing Co., Inc., 919 North Michigan, Chicago, and 101 Park Avenue, New York. Otho F. Ball, president; Raymond P. Sloan, vice president; Stanley R. Clague, secretary; J. G. Jarrett, treasurer. Yearly subscription, United States and Possessions and Canada, \$3; foreign, \$4. Single current copies, 35 cents; back copies, 50 cents to \$1. Charter member Audit Bureau of Circulations. Copyright, 1937, by The Modern Hospital Publishing Co., Inc. Entered as second-class matter, October 1, 1918, at the Post Office at Chicago, Ill., under the act of March 3, 1879. Printed in U. S. A.

CONTENTS

geons of Columbia University, will discuss this question and the editor will point out hospital implications.

THE palm print method of identifying infants, originated by Dr. Gilbert Palmer Pond of West Suburban Hospital, Oak Park, Ill., has attracted a great deal of attention among hospitals, identification experts and the lay public. Next month Doctor Pond will give details regarding the technique of taking the prints. Any intelligent nurse can be quickly trained to take good palm prints.

SOMEWHAT over a year ago The MODERN HOSPITAL asked whether we faced an impending shortage of nurses. At that time it was almost heresy to use the word "shortage" in such a connection. Since then the theoretical shortage has actually materialized in many communities. Hospitals are turning hopefully or desperately to various expedients. Salaries have gone up, although not in many cases to predepression levels. But even higher salaries are not effective when there just are no nurses. Many institutions are experimenting with attendants to do some of the work heretofore considered part of nursing. There are admitted dangers in this practice, yet also benefits to both hospitals and nurses, if properly controlled. Dr. Fred G. Carter, superintendent, Christ Hospital, Cincinnati, writes next month about the extensive experience that institution has had with attendants. His experience is revealing and encouraging.

WHEN should a hospital establish a special clinic? Does the enlarging of special types of clinics cut down on the educational value of the general clinics? Is it desirable to break medical practice into still smaller fractions? Perhaps we already are too vulnerable to the jibes about "left-handed tonsil snatchers." On the other hand, do we not lose something in interest, enthusiasm and skill if we throw all types of cases into general medicine and general surgery? John E. Ransom, assistant administrator, Johns Hopkins Hospital, presents the dilemma next month and suggests a way out. All clinic administrators will welcome his sane pres-

Service Without Price.....	75
Is given by the volunteers at Cook County Hospital, asserts M. H. MOOREHEAD, director of volunteers, Cook County Hospital, Chicago.	
Occupational Therapy — Wise and Unwise.....	77
As seen by ROBERT B. MCGRAW, M.D., and AGNES CONRAD, M.D., of the departments of medicine and psychiatry of the College of Physicians and Surgeons, Columbia University.	
Doing Right by the Neurotic Patient.....	81
A plea for more understanding, sympathy and tact in dealing with those who have nervous breakdowns, by WILLIAM C. MENNINGER, M.D., Topeka, Kans.	
Keep the Life Stream Pure.....	85
Further facts, historical and medical, concerning the blood and its diseases by JOSEPH C. DOANE, M.D., the editor.	
Better Than an Employees' Union.....	88
That employees' unions, under whatever name they choose to operate, should be recognized by administrators is the experience of ABRAHAM ROSENBERG, assistant director of Hospital for Joint Diseases, New York City.	

PLANT OPERATION

Hospital Contracts to Pasteurize.....	90
ROBERT E. NEFF, administrator of the University Hospital of Iowa, promises you a surprise if you run tests on your milk supply. His article gives pertinent data on his hospital's pasteurizing plant.	
System in Handling Linen.....	96
A housekeeper should keep records on the linen supply, says BLANCHE I. NEWTON, housekeeper at Grace Hospital, New Haven, Conn.	
Adapted to Brain Surgery.....	98
Is the table described by CHARLES E. REMY, M.D., superintendent of Minneapolis General Hospital, Minneapolis.	

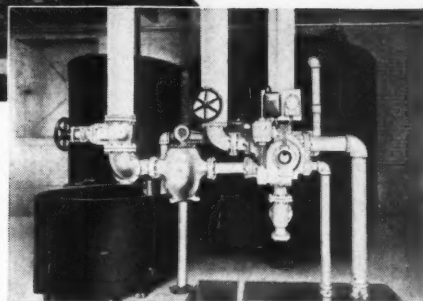
FOOD SERVICE

Silver for Beauty and for Use.....	100
Good silver, well designed and well cared for, is needed for an efficient food service, says ANNA E. BOLLER, the editor of the food service department.	
In Accordance With Kosher Law.....	104
The hospital kitchen must become two — a dairy kitchen and a meat kitchen. IRMA E. REAVES, dietitian, Mount Sinai Hospital, Chicago, tells of the arrangements which are in force at her institution.	

Hospital Barometer	8	News in Review.....	112
The Editor Talks It Over.....	38	Names in the News.....	120
What Others Are Doing.....	56	Reader Opinion	122
Someone Has Asked.....	84	Literature in Abstract.....	124
The Housekeeper's Corner.....	94	Books on Review.....	130
Recipes by Request.....	106	New Products	132
Food for Thought.....	108	Index of Advertisers.....	10
Tray Service	108	Want Advertisements (Posi-	
Breakfast and Supper Menus.....	110	tions Wanted, Open, etc.).....	145



Soft Water Saves Ohio Valley General Hospital \$4,575 Yearly



A PERMUTIT WATER SOFTENER is simple and easy to operate. Hospitals invariably save large sums in laundry and operating costs, by installing Permutit Equipment similar to the above

The Ohio Valley General Hospital at Wheeling, West Virginia, with 275 beds and a nurses' training school, is one of the most thoroughly equipped modern hospitals in the country. And it is modern in its management as well.

So when the local water supply, with 7 grains of hardness per gallon, caused continuous and costly trouble in the boiler plant, laundry, and throughout the hospital generally, the management investigated methods of solving the problem. The decision was made to use Permutit Water Conditioning, and according to the Superintendent's report this is what it saves them annually:

Saving of fuel for boiler and water heaters. . . . \$1,200

Saving of periodical cleaning of boilers and heaters.	300
Saving on renewing boiler tubes, pipe lines and water backs.	500
Saving of boiler compounds.	100
Saving on laundry, kitchen and house soap. . . .	800
Saving on laundry sodas.	75
Saving on special soaps, chemicals and scouring powders.	50
Saving on linen renewals.	1,500
Saving on renewing sterilizing coils.	50
TOTAL.	\$4,575

What would Permutit softened water do toward reducing your budget? Investigate today by sending for a copy of "How Soft Water Saves Money in a Hospital."

Permutit

Water Conditioning

THE PERMUTIT COMPANY, Dept. E,
330 West 42nd St., New York City

Please send me without obligation your booklet, "How Soft Water Saves Money in a Hospital," and complete details about the purchase of equipment under the terms of the National Housing Act.

Name.

Position.

Hospital.

Address. City.

The Editor Talks It Over

• Does your staff annoy you by asking persistently for the loan of instruments, supplies and other hospital property? An intravenous set with a flask of normal saline for use in a family residing near the hospital, instruments to be used outside of the institution for the removal of a plaster cast, syringes for chest and abdomen tapplings, dressings for a fracture, these and many other articles often required by the physician and seldom available to him from his own office are the subject of such requests. The hospital should be obliging but not easily submissive to impositions and losses which result from the granting of such favors. On the other hand, the executive must remember that those who apply are his sales agents and whenever possible should oblige them.

• The physician must employ to the fullest degree all of his special senses if he is to diagnose and treat disease successfully. It has even been hazarded that a sixth sense, usually called "common," is necessary in unraveling a complicated diagnostic problem.

The olfactory sense is not the least needed by the doctor in the pursuit of the art and the science of medicine. He is often able thereby to diagnose chronic nephritis by the uremic odor of the patient and diabetic coma by its distinguishing sweetish acetone odor. A patient suffering with typhoid fever is said to emanate a mousy odor and he who is unfortunate enough to suffer from acute articular rheumatism has an acetic acid aroma.

Moreover, the skilled physician who passes down a hospital private floor corridor may often guess by the use of his olfactory sense the diagnosis of the patient being treated in the rooms which he passes. A fragrant wintergreen odor suggests acute articular rheumatism or some of its variations, the spicy turpentine odor, that abdominal distension is being treated by stupes and the aromatic vapors of compound tincture of benzoin reminiscent of the North woods imply that some patient is suffering from a bronchial ailment and is using a steam generating inhaler.

The hospital executive employing his

olfactory sense is able to detect more mundane things than the diagnosis of disease. With equal certainty his sense of smell leads him to the hiding place of a sodden and unclean mop or to the existence of insanitation which careless cleaners had thought well hidden. Employing both their olfactory equipment and their supply of common sense both the physician and the hospital executive may at times display what appears to be unusual, though in reality perfectly commonplace, diagnostic powers.

• The physical examination of probationary nurses should be searching and thorough. The presence of a heart murmur may mean little to the health and usefulness of a school girl in the community. But, when through infected teeth or tonsils or the exposure to virulent organisms encountered in nursing, diseased heart valves become again infected, the deadly bacterial endocarditis results.

It is a decided and distinct obligation of the hospital to reject applicants on the basis of physical defects of any sort which, because of the nature of their institutional work, will be likely to aggravate existing pathologic states. It is a mistake to yield to the importunities of a handicapped individual who above all else desires to enter a school for nurses. She might maintain her health as an office secretary or a sales girl or in some other useful vocation, while an arduous training course might break her down.

• Those who have read "An American Doctor's Odyssey" by Victor Heiser, M.D., can fully appreciate the difficulties thrown in the way of the government sanitarian by red tape and political disbelief. Hospital administrators who are discouraged because of the difficulties that present themselves should take heart in reading the story of the accomplishment of such scientists as Heiser, Gorgas and others who, almost singlehanded, conquered in the far off corners of the earth the scourge of disease and thus opened new lands to commerce and to travel.

Newton Baker, former Secretary of War, in his interesting narrative delivered at the dinner of the American

Hospital Association in Cleveland, threw new light upon the insight, the simple persistency of General Gorgas who when sent to Cuba to combat yellow fever analyzed the problem confronting him in these words, "If yellow fever is transmitted by the mosquito, then the solution lies in killing this insect."

The whole world laughed at the apparent insouciance of such an analysis of the situation. The press caricatured the redoubtable Gorgas with fly swatter in hand pursuing the evasive stegomyia. But those who ridiculed were in the course of a few short years confounded by their own previous disbelief and ignorance. Today in the minds of the scientific world the activities of Gorgas alone are responsible for the sanitation of Havana and the existence of the Panama Canal teeming with world commerce.

• Professor James Alexander Miller, in his opening address to the medical students of the College of Physicians and Surgeons in New York in September, discussed in considerable detail those many troublesome situations which confront the young physician when he is ready to open his office.

His remarks relative to economic matters as they affect the hospital were sane and constructive and should serve to direct the thoughtful attention of young physicians to this much discussed and little understood subject. He pointed out that the criticism directed toward the abuse by patients of hospitals and dispensaries is not entirely unmerited but that it was his belief that the situation would be largely corrected if the public could be assured of the same standard of service from private physicians as it expects to find in the hospital. If, concludes this observer, there is truth in this statement the solution of this problem is to be found in the improvement of private practice.

Surely, the advice of one who has attained such distinction in the practice of his profession as has Doctor Miller should be heeded by the medical profession in general. The hospital in turn should do its part to reduce to a minimum the free treatment of persons able to pay.

Serve More Patients in Less Time! STERNO HOSPITAL SERVITOR



NOW hot, appetizing food can be served in the least possible time! Hospital labor costs for meal service cut to a minimum!

It's like rolling the diet kitchen to the patient's door! For one round trip with a Sterno Hospital Servitor makes it possible to serve many times the usual number of patients.

Food in the aluminum servitor is

kept piping hot by Sterno Canned Heat, the safe fuel. One can of Sterno does the trick! Sufficient to keep food warm until it's served!

Each tray may now be made up at the patient's door... served immediately. Or if individual meals are assembled below, they may be carried in the servitor, kept hot and ready for service to the patient.

Hospitals now using the Sterno Servitor find it saves the staff hours of labor... many unnecessary steps every day. It makes for economy... added efficiency in hospital management.

Investigate today! The cost is moderate for both the Sterno Hospital Servitor or the individual Sterno Room Service Food Carrier. Use the coupon below to obtain desired information.

HOSPITAL AUTHORITIES!

Individual Sterno Room Service Food Carriers and the new standard Sterno Hospital Servitors are now available... If these do not meet your institution's needs, let us discuss your requirements with you. Just mail this coupon for free information. You incur no obligation.

STERNO CORPORATION, HOSPITAL DEPARTMENT
9 East 37th Street, New York City

Gentlemen: Please send me complete information about:

- ☐ Standard Sterno Hospital Servitor
- ☐ Individual Sterno Room Service Food Carrier
- ☐ Special Information

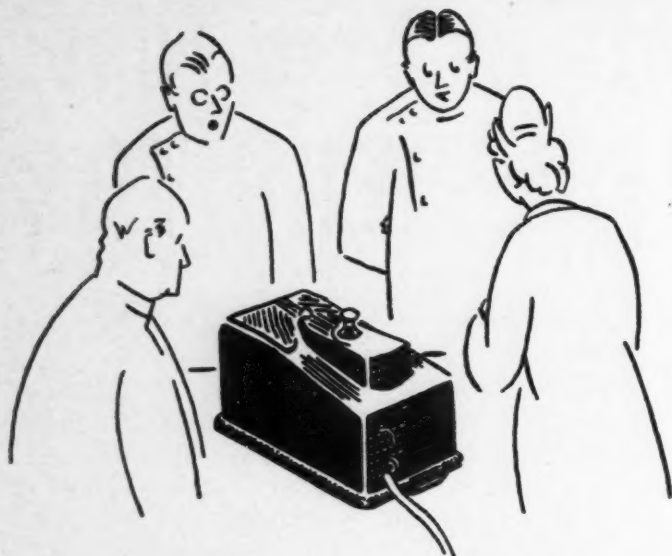
Name _____

Hospital _____

City _____

State _____

MH-1-37



"Splendid"

will say the staff

"A Fine Investment"

the directors will agree



WHEN your first G-E Inductotherm is placed in service, the favorable reaction of the medical and nursing staffs will parallel that of similar groups in similar institutions the world over. "Splendid", they will say.

Then, the efficiency of the machine; the diversified and important uses to which it will be put; the economical and satisfactory service it will give, will earn for it the approbation of your directorate. "A fine investment", the members will agree.

Idle prophesies? By no means! Every hour of the day, every day of the week, every week of the year an Inductotherm is being installed or is in use—somewhere. From these hundreds of cases we have learned what experience you may expect to have. As it has been with others—so will it be with you.

Arrange, by writing to us NOW, for a really practical, non-obligating demonstration of the G-E Inductotherm—to be given before your staff, if you so desire. Address Dept. F11.

**GENERAL  ELECTRIC
X-RAY CORPORATION**

2012 JACKSON BLVD.

CHICAGO, ILL., U. S. A.

The G-E Inductotherm produces heating of the deep tissues by electromagnetic induction, which is acknowledged by competent observers to be the most effective method available.

In treatment of local areas; for alleviation of pneumonia; for production of electroparalysis, the Inductotherm stands alone—at the top!

Do not confuse it with other machines offered for the same purpose.

Looking Forward

Some Things to Think About

DURING 1936 voluntary hospitals enjoyed an occupancy well ahead of the 1930 average. This represents a steady gain since the low point in 1932 and 1933. Collections have improved and the demand for pay accommodations is mounting steadily.

During the depression years many hospitals used space to expand their auxiliary services. This space usually cannot be reconverted into patient accommodations.

The recent rain of wage increases, holiday bonuses and dividends and the advancing prices of many farm products undoubtedly are building a larger purchasing power on the part of nearly all classes. This will be reflected in a still further demand upon hospitals for pay service.

Already some institutions have felt the urgency of this demand. Hospital construction projects started during 1934 totaled just over \$39,000,000. In 1935 the total was \$41,000,000. To December 21, 1936, the yearly total was \$96,000,000.

Part of this expansion is due to government expenditures and even including this, it is still much below the average of \$200,000,000 a year recorded for the twenties. But there are many indications that 1937 will see a further substantial rise in hospital construction.

Before deciding on a construction program, hospital administrators and boards should carefully review all the questions of general policy that were germane (although sometimes woefully neglected) in the twenties. These include careful consideration of the hospital's function in the community, its relation to other hospitals, and the character of the groups, both practitioner and patient, which it will serve.

But there are now several new factors which must also enter into the balance. They fall into four general groups.

The first concerns pay patronage. Will the increased purchasing power of the middle and lower income groups mean more paying patients for voluntary hospitals? Is this increase merely temporary or will it probably continue? Does

group hospitalization give evidence of providing a substantial source of increased income for hospitals? Will it remain chiefly a middle class effort or will it seep down to the poorest paid?

The second group of questions concerns philanthropy. Will a new group of wealthy individuals be created by the rising business activity who may be counted upon to aid hospitals? Will they be sufficient in number and in wealth to take the place of those who lost all or most of their fortunes in the last six years? Will corporations accept responsibility for social welfare and thus supplement the gifts of individuals? Will the new forms of taxes stimulate or discourage corporate and private benefactions?

What about the actual details of construction? Is this a good time to build from a cost standpoint, considering both labor and material costs? Should construction be undertaken only when it can be paid for in cash or can a reasonable debt be assumed? What is now a reasonable "debt"?

Finally what will be the attitude of governments? If the load of free patients decreases, will government general hospitals accept paying patients? Or will governments confine themselves to providing care for those who cannot be adequately cared for in voluntary hospitals?

This is not a time for timidity and weakness. The hospital which fails to provide an adequate physical workshop for its doctors will lose ground. At the same time, the lessons of the depression must not be forgotten and clear, honest analysis should replace wishful thinking.

A Tribute

LEWIS ALBERT SEXTON, M.D., died at Hartford, Conn., on December 3, 1936. Thus reads the cold chronicle marking the close of a varied career which began in 1899 as a student in pharmacy and chemistry at the Vanderbilt University in Nashville, Tenn., and culminated in the superintendency of one of the country's finest hospitals and the presidency of the American Hospital Association.

Too infrequently does the hospital world pause in its daily labors to mark the passing of those

who have rendered distinguished service in the field of institutional medicine. But simply to record the places filled by such men and women is to overlook the persisting influence which always follows like the evening afterglow—the setting of the sun of a useful life.

Doctor Sexton rose through the ranks. He was acquainted with the administration of institutions for the care of the indigent and the contagious, before in 1914 he became assistant superintendent of the Johns Hopkins Hospital in Baltimore. The six years spent at the Willard Parker Hospital in New York City certainly served to acquaint him not only with the details of the administration of a special institution caring for the exanthemata but also with the clinical behaviour of contagions in general.

In 1917 Doctor Sexton was ready to assume larger executive responsibilities, and in that year was appointed to the superintendency of the Hartford Hospital. During the almost two decades which marked his term of service in this institution he brought about many outstanding structural and administrative changes. He cherished the medical degree bestowed upon him by Vanderbilt University, maintaining his membership in the American, Connecticut and Hartford County Medical Associations.

Such are the main chronological facts in the life of Doctor Sexton. But these tell but little of his ever present courtesy to his colleagues, of his skill as an executive, of his ability to command and retain the respect of the men of large means and influence in his adopted city and state. As president of the American and New England Hospital Associations he was always the dignified, skillful leader. The hospital field has lost one of its distinguished representatives.

Menace or Nuisance—Which?

A MENACE to human lives and a neighborhood nuisance—that is what some hospitals actually are. Class A hospitals, at that! These hospitals, let us hastily add, are entirely innocent of evil intent; they have not known the truth about themselves.

Last winter a hospital in Cambridge, Mass., was horrified to learn that it was the cause of the complete cessation of important work being done at the Naval Research Laboratory in Washington, D. C. The hospital's diathermy unit was broadcasting a "sky wave" of such intensity that radio communication at this laboratory was impossible.

The hospital's short wave machine, it was found, was not equipped with a filter and the

radio frequency energy was fed back into the power wires which acted as an antenna. The insertion of a suitable electric filter between the apparatus and the power line was all that was necessary to stop most of the trouble.

Human lives depend upon radio messages between ships and shore, airplanes and ground and various directional signals. Man-made, hospital-made static is thus more than a potential nuisance to every radio owner deriving power from the same line as a hospital with an improperly filtered diathermy unit. It may be a menace to life and property.

The council on physical therapy of the American Medical Association is expected shortly to alter its requirements for acceptance of electrical equipment of the type which has caused interference with radio communication. Manufacturers will be asked to submit evidence that specifications for construction and installation of these devices will prevent such interference.

In the meantime hospitals may well obtain such additional equipment and engineering advice from the manufacturers of their present equipment as will take them out of the menace and nuisance class.

The Nurse Anesthetist

HERE and there opposition among physicians flares against the nurse anesthetist. She is charged with practicing medicine without a license. She is said to be inefficient and officious. The hospital which employs her is listed as a profiteer on the service of others in that it collects from private patients several times the amount of her salary.

It will be illuminating to some to examine the facts in the case. It is conceded by most surgeons that a well trained nurse anesthetist is capable of providing a high safety factor to the patient—that she is efficient and conscientious and is concerned only with the immediate business at hand and not with the operation. Moreover, the objection to her employment rarely emanates from the surgeon. The trained physician anesthetist, and there are too few such, is the source of most complaints against the nurse in anesthesia.

There is little said as to the safety of the patient in her hands and much as to the legality of employing nurses in this capacity. As to the latter item it has been decided on more than one occasion that the physician is responsible for the acts of his assistants and that the nurse who administers by the doctor's order a drug by inhalation is no more practicing medicine than one

who, following a physician's direction, injects a medication subcutaneously.

The hospital is not guilty of unfair practice in its dealings with the anesthetist unless it also is equally guilty in respect to its charges for other special services which include both the activities of personnel and the use of supplies. Unless it can be proved that nurses are less safe than the average physician who is not a specialist in anesthesia, there seems little to justify the hospital in altering its present system.

Reciprocity in the Realm of Ideas

THE International Hospital Association was launched at Atlantic City in 1929 through the work, in considerable measure, of American hospital administrators, notably Dr. S. S. Goldwater, Dr. Walter H. Conley, Dr. E. H. L. Corwin and several others. Dr. Corwin was the first secretary general. The association was officially formed two years later at a meeting in Vienna.

In spite of this active initial leadership by Americans, the interest on this side of the Atlantic lagged during succeeding years and most of the responsibility fell on other shoulders.

At the 1935 meeting in Rome, the association was considerably reorganized and Sydney Lamb of Liverpool was chosen as general secretary and treasurer. Through the energetic work of Mr. Lamb and his associates the debt of the association has been cleared and its activities carried on with increasing effectiveness and vigor. The association's magazine, "Nosokomeion," under the competent editorship of Dr. W. Alter, is appearing at regular quarterly intervals. It provides much information on comparative hospital practices in various countries. It now appears that the association is carefully managed and effectively operating. Its biennial congresses are well attended and the hospital study tours in intervening years are reported to be interesting and valuable.

The study and interchange of ideas carried on by the association not only benefit each member personally but definitely aid in accomplishing the common purpose of all hospitals—better care of the patient. Furthermore every successful effort to pool information and ideas of various countries is a definite step toward much needed harmony among nations. Hospitals rest on a basis of science which is the joint contribution to civilization of fine minds in every civilized country. Surely hospitals, therefore, should be most understanding of the universality of their science and ready at all times to share it with those in

other countries. The International Hospital Association offers a splendid opportunity for outstanding administrators of America to demonstrate their awareness of this international obligation.

Dr. Malcolm T. MacEachern, vice president of the association for the United States and Canada, invites hospital administrators of these two countries to join the association as associate members (active members are the national hospital associations). A payment of \$10 will cover associate membership dues for two years. Checks may be sent to Sydney Lamb, 87 Lord Street, Liverpool, England. Members receive the official journal of the association and their membership card assures them a cordial welcome by hospital people in nineteen nations.

Wanted—a Broader Vision

IT IS difficult for an individual to consider the broad needs of a community when in his opinion by so doing his own interests are likely to suffer. It is true that while self-preservation is nature's first law the practical application of this dictum is likely to produce exaggerated examples of selfishness difficult to reconcile with the high ideals of a profession which purports to serve.

Thoughtlessly and often erroneously the staff physician sometimes applies this theory to his intrahospital activities. He disfavors a fracture service because such an innovation might lessen the experience and income which he might expect as a general surgeon. The cancer, diabetic, orthopedic, rectal and gynecologic cases are, even in large hospitals, often referred to the general surgeon because of a fear that his prestige and practice will be lessened if surgical specialists are given a place on the visiting staff. In one locality no interns are found in the local hospital because after finishing their course, young physicians are likely to settle near by and enter into competition with local doctors.

Such an attitude deserves the strongest public condemnation. It can be justified only if the obstructing physicians by training and experience can offer a medical service equal to the best a specialist can supply. In the last named instance the hospital board should overrule every effort of the staff to corner the medical market and engage interns if the needs of the patient call for such a step, whether the staff approves or not. The doctor was created to serve the community and not the latter to minister to the needs of the former.

Next Objectives

By THOMAS PARRAN, M.D.

AMONG the many factors that contribute to health in this country, care of the sick is perhaps the most important. Those who are ill represent a group that have lost something which must be restored if they are to survive and to continue as productive members of society. In this restorative process the use of techniques and facilities in various combinations is required.

It is to the hospital that people look for that type of care which cannot be provided in the physician's office or in the home. Several forces are operative which tend to increase the proportion of patients that should be treated in hospitals. Notable among these forces are changes in living conditions which render the home less suited than formerly to the needs of the sick. Another factor of almost equal importance has arisen out of advances in diagnosis and therapy, that is, the necessity of having at hand equipment and skills which cannot be provided through the resources of the individual patient and his physician. It is not probable that there shall be any immediate reversal in the trend toward more frequent hospitalization; certainly any slowing of the pace is not perceptible at the present time.

Despite statements to the contrary, there is no surplus of hospital beds if existing facilities are considered in relation to need for service. The people of many areas are required to travel excessive distances before reaching the nearest hospital, while in other places one finds the striking paradox of empty beds and patients who cannot be admitted. In one instance there is need for new construction; in the other the problem is that of removing the financial barrier between the service and the person who needs it.

Must Open Doors to New Types

The public health officer in particular appreciates the need of better provisions for patients afflicted with acute communicable disease, tuberculosis or venereal disease. Few communities, except the large centers of population, are in position to maintain institutions for such specialized

care. In every community, however, a significant percentage of communicable disease patients should be treated in a hospital. If accommodations in general hospitals were satisfactory, a number of physicians might choose to treat tuberculosis patients in the areas where they reside. An individual with acute gonorrhea or syphilis often finds difficulty in obtaining admission to a general hospital even though the necessity for hospital care is clear.

Refusal on the part of general hospitals to admit any of the three types of patients just enumerated may in some instances be excused on the grounds of unsuitability in the structural arrangement of the plant. More often than not it represents an attitude for which there is no scientific or social justification.

The second rôle in community service, which through the ages has been associated with hospitals, is care of the ambulatory sick. Not so long ago practically every well organized hospital either had or hoped to have some day an out-patient department at which the poor of the community might obtain highly specialized services that could be made available through the staff. While new out-patient clinics are being organized from time to time, yet there has been considerable lag of interest in this important element of hospital service. Such an attitude is to be regretted since organized clinics especially in large centers of population present many advantages over other systems that have been devised for furnishing care to the poor who are ill.

Reforms in Clinic Service

Before out-patient services of hospitals can go forward with renewed vigor, it will be necessary to correct abuses which were all too common in medical dispensaries of the old type. Patients should not be required to wait hour after hour under uncomfortable circumstances, and finally receive a hurried impersonal type of service. Furthermore, there must be an end to the exploitation of physicians. This applies not so much to the very small percentage of clinic patients whose income may exceed the standards of eligibility for admission as it does to the large volume of service that is rendered by the medical staff on a gratuitous basis. Except in a few instances, the prestige or experience attached to a clinic appointment is not in itself sufficient reward for the younger physicians who carry the largest share of the burden.

Clinical and public health practice of the present day demands the use of physical equipment

that must be purchased at considerable expense. In this list may be included x-ray, electrocardiograph, chemical and bacteriologic laboratories and equipment for the common forms of physiotherapy.

These facilities and the technical skill required for their operation are not likely to be found in the smaller cities or even in many places of moderate size unless the community resources have been pooled. The hospital, because of its peculiar relationship to professional groups and to the community, might well be the agency in which are merged those local resources that could be used alike by the practicing physicians in caring for their patients and by the public health organizations in the discharge of community responsibilities.

Clinical records in hospitals of this country must represent a vast storehouse of scientific information, yet it is surprising how seldom these data are used in studying the mass expression of illness. Most analyses of hospital records are the result of an interest which a staff member has in a clinical condition. Not infrequently the cases are drawn from his own service; consequently the numbers tend to be small and the patients are likely to show considerable selection from one or several points of view. As a rule, the best of clinical practice is portrayed in this experience.

It is true that certain hospitals make tabulations which include all or a large percentage of the admissions, but generally speaking these analyses are designed primarily to meet the routine requirements of the administration office. Little consideration is given to the possibilities of evaluating diagnostic and therapeutic procedures through the use of hospital records. From the standpoint of the general medical profession and the hospital administrators as a group, it should be of great interest to learn what occurs when good procedures are used under circumstances that represent different degrees of perfection in physical equipment and professional skill.

Need for Uniform Accounting

Recently the Public Health Service has had occasion to collect and analyze certain data bearing on hospital administration. Variations found in the figures submitted by similar institutions strongly suggest that hospital authorities give different interpretations to common terms. There also seems to be a lack of uniformity in accounting practice which must further reduce the reliability of figures commonly used to portray the general picture of hospital services and finances.

Under the stimulus of the national associations whose 1937 programs are presented on pages 59 to 63 hospital service should go forward rapidly

The traditional conception of a hospital is that of a place to which an individual may go when he is sick. A large majority of hospitals still center their attention on the patient while he is in the institution but give little thought to other vital problems in the individual's life, such as, Why is he sick? What personal, family and community problems are precipitated by his illness? What will become of him when it is time for him to leave the hospital?

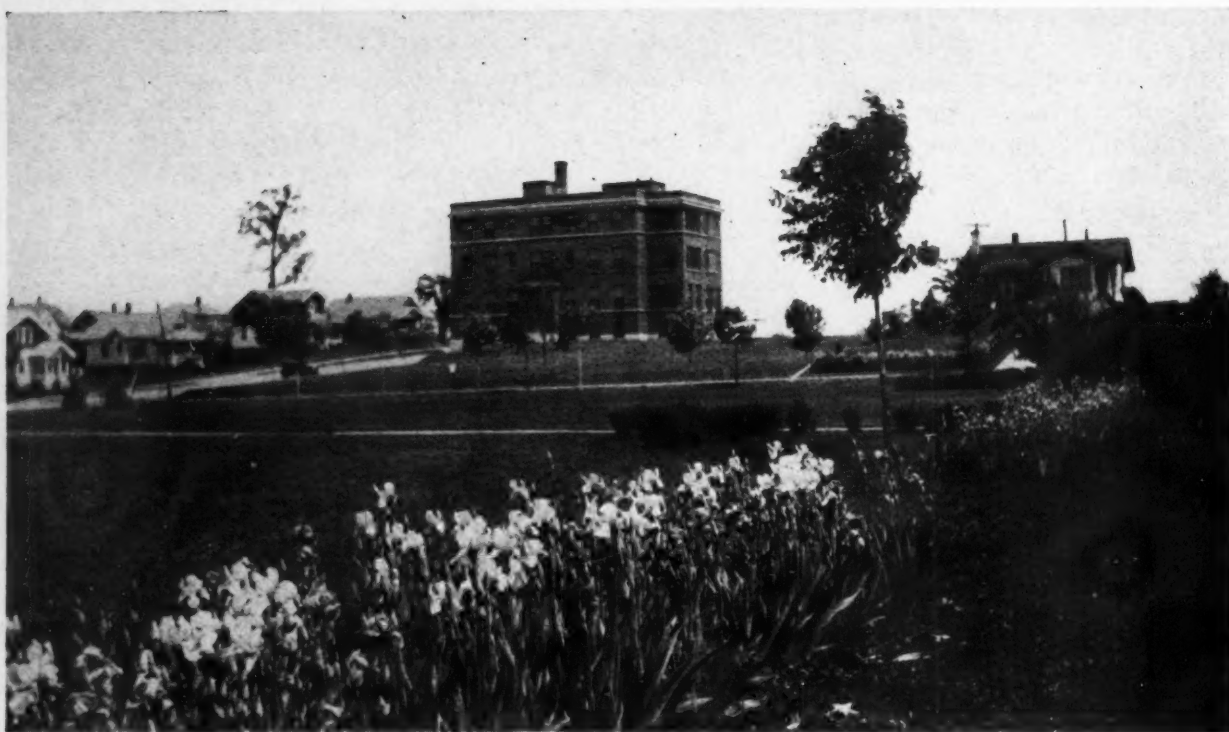
These problems may not impose any great responsibility on the hospital when the patient is cared for by a personal physician, but when the patient is dependent on the staff, it is incumbent on the hospital organization to broaden its interest in the sick individual.

All too commonly the health department will be found occupying another extreme position, busying itself with a few hazards in the general environment. Problems peculiar to the hospital and, in fact, the whole question of medical care have not as yet arrested the attention of public health agencies. Perhaps it is well that hospitals and public health agencies should have progressed so far under different auspices, but the time has arrived for developing working relationships between two agencies that occupy fields which now overlap.

Most Important in Prevention

One advantage of cooperative enterprise, that of economy in the use of facilities, has been stressed. Certain intangible benefits in the way of a broader understanding of the whole health problem are destined to evolve from the exchange which is possible in this partnership. It is altogether possible that the hospital may be the most important single contributor to the prevention element in the program of future public health service.

The hospital of 1937 and of succeeding years must consider itself not as an isolated institution for the treatment of the sick, but as an integral part of the community's effort to cure disease by all methods known to science.



General Hospital of Iron River District, Stambaugh, Mich.

Five Life-Saving Stations in the North Woods

By ALDEN B. MILLS

TO MOST Middle Westerners the North Woods and the Iron Range spell vacation. Fishing, hunting, canoeing, camping—these are considered the principal occupations on the Michigan peninsula and in upper Minnesota. Deer, bear, "muskies" and trout are thought to be the leading inhabitants of Paul Bunyan's great domain.

While thousands do escape to the North Woods each summer when the heat of the Middle West becomes too oppressive, tourists are but a seasonal phase of life there. Year in and year out there is a substantial population in the smaller towns and the country side and for these people there is a constant need of hospitals. Some are farmers but more are miners, bringing out the iron ore which is shipped in such large quantities from Duluth and other Great Lakes ports.

What kind of hospital care is provided to these people? To answer this question a visit was made to typical hospitals in Michigan and Minnesota.

The first stop is in Stambaugh, Mich. Iron River, Caspian, Gaastra, Mineral Hills and Stam-

baugh are five small cities so close together that it is difficult to tell where one ends and the next begins. There is only one hospital in the five cities and, indeed, it serves a considerable rural area.

Few hospitals can claim a finer location. On the top of the highest hill a civic center has been built. In the center is a large lawn, decorated here and there with beds of flowers. In June tall magnificent iris bloom there. Young trees, planted along the walks, will in a few years make impressive shade. At one end of the center are the grade and high schools. To their left is the modest little building of the free public library and to their right, on a still higher eminence, is the hospital.

Behind the hospital down a little valley is still more park, this part, however, given over to public recreation grounds with tennis and shuffle board courts, football and baseball fields, running tracks and around the sides of the bowl ample room for an audience of several hundred.

This twenty-seven-bed general hospital in Stambaugh was built in 1931 by joint action of the nine mining companies of the region at a cost of

\$115,000. Since then they have continued to support the hospital and have apportioned its operating deficit among them on the basis of their average number of employees. The deficit, however, has been steadily decreasing. For the first year it was \$11,000. Last year it had dropped to only \$4,000. And this is the more remarkable because Iron County has been more severely affected by unemployment than most areas. Even now most of the miners have only three or four days' work a week.

But we are getting ahead of the story. First let us see the hospital.

We are guided on this tour by the superintendent, Mabel Overett. Miss Overett has had many years of hospital experience starting with training in St. Giles Hospital, London. During the World War, she served with the Queen Alexandra Imperial Military Service Reserves. Following the war she came to the United States and spent some time in Duluth, Minn. In 1926 she was called to Wakefield, Mich., to open the thirteen-bed mining hospital there. When the Stambaugh hospital was opened she was called to administer it.

Let us start with the basement because a basement is such a good indication of the care given to an institution. Our first look is in the boiler room. Although there is no sign asking the visitor to wipe his feet, the floor is spotless. It is crowded with machinery, boilers, electric control

boxes, automatic stokers, water softening equipment and plumbers' and carpenters' tools. Everything is in its place and shining. It is obvious that Miss Overett and her entire staff are good housekeepers.

Down the hall from the boiler room is the all electric kitchen. Electric stoves, ovens, dishwasher, mixer, ice cream freezer, broiler and a large electric refrigerator justify the term "all electric." Central tray service from this kitchen provides rapid food service to the adjacent employees' dining room and, via an electrically heated dumbwaiter, to patients on the second and third floors. The ground slopes away more steeply on the front of the hospital than in the rear so that the dining room is fully above grade. The kitchen is manned by a cook and a maid. Miss Overett acts as dietitian and plans all the meals.

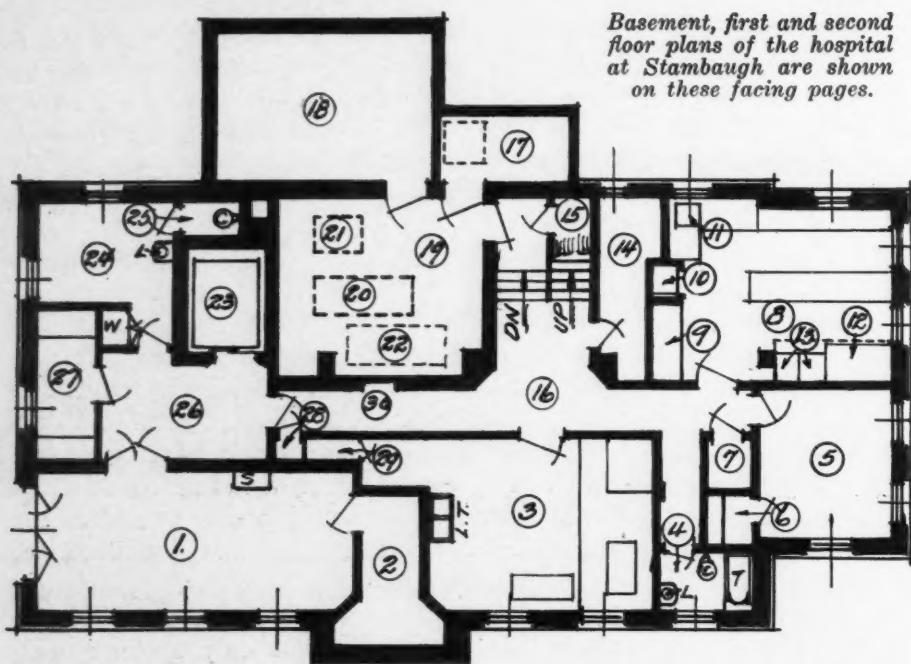
Also on the basement or ground floor is the laundry. Although there is only one laundress, with occasional help she does the work for the entire hospital. The secret is a well planned and fully equipped laundry.

At the far end of the first floor is a room originally designed for an ambulance but now used as a storeroom.

The first floor contains the business office and superintendent's living suite, the operating room, sterilizing room and other subsidiaries, the clinical laboratory, the drug room, the x-ray laboratory, nurses' rest room, doctors' rest room and



Shipman Hospital with its large old-fashioned garden stands on a prominent corner in Ely, Minn. A low hedge and a row of American elm trees surround the grounds, planted by the owners of the hospital.



Basement, first and second floor plans of the hospital at Stambaugh are shown on these facing pages.

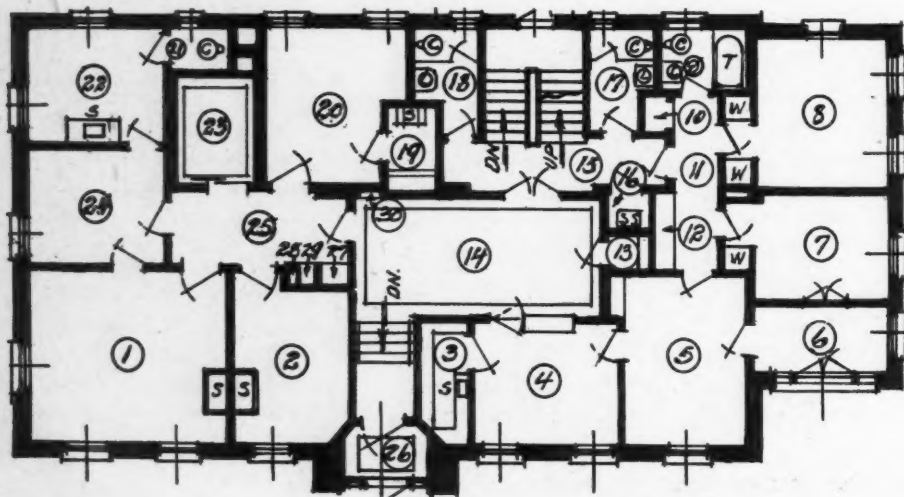
Plan of the basement—(1) ambulance garage; (2) storage; (3) laundry; (4) cook's bath; (5) cook's room; (6) closet; (7) closet; (8) kitchen; (9) refrigerator; (10) dumb-waiter; (11) dishwasher; (12) range; (13) bake ovens; (14) kitchen storage; (15) storage; (16) corridor; (17) ash room; (18) coal bunker; (19) boiler room; (20) main boiler; (21) hot water and garbage burner; (22) hot water storage; (23) elevator, pushbutton type; (24) man's room; (25) toilet, man's room; (26) elevator, lobby; (27) storage; (28) soiled bandage receptacle; (29) soiled linen receptacle; (30) hose cabinet.

public toilets. Although accidents from the mines have been reduced almost to the vanishing point, this hospital and all the other mining hospitals visited have excellent, modern x-ray equipment. It is extensively used by the physicians for accident cases, mainly auto accidents, and for therapy.

The location of laboratories on the first floor is a reflection of the close coordination of the hospital with the community's doctors. All of the physicians in the community may and most of them do bring ambulatory patients into the hospital for the laboratory and x-ray work. The physical examinations of miners at the time of employment are made here. There are three physicians employed by the mining companies, one by the CCC camps and several in private practice, all of whom use the hospital for both ambulatory and bed patients. Specimens of tissue that cannot be properly handled in the hospital's laboratory are sent to Ann Arbor or to Chicago.

The third floor is devoted to the maternity department with delivery and labor rooms, nursery, and rooms for mothers. Since this floor is exclusively for maternity patients there is little chance of cross infection from the surgical or medical patients. The second floor is for all other types of cases and is devoted to accommodations for patients. There is an attractive solarium on each of these floors.

Part of the popularity of the hospital is due to the fact that the equipment for patients is of the best. Every bed has a thick, comfortable mattress; there is running water and a private toilet in each room. There are no large wards. Food is quickly served through the central tray service, and each patient has his individual nurse's call, a convenience taken for granted in large city hospitals but often not provided in institutions of this size. All nursing is done by graduate nurses, who are paid \$67 a month. Miss Overett



Plan of first floor—(1) operating room; (2) receiving room; (3) drug room; (4) office; (5) sitting and dining room; (6) porch; (7) matron's room; (8) nurse's room; (9) private bath; (10) dumb-waiter; (11) passage-way; (12) linen closet; (13) public telephone booth; (14) waiting room; (15) stair and rear corridor; (16) janitor's closet; (17) women's toilet, public; (18) men's toilet; (19) dark room; (20) x-ray room; (22) laboratory and surgeons; (24) sterilizing room; (25) elevator lobby.

has not experienced any difficulty in obtaining competent nurses. There is a radio outlet in every room.

The construction is fire resistant and in addition there is a fire alarm system. Michigan passed a law recently requiring public buildings of certain sizes to have fire escapes. While the chances of fire are remote here, in order to comply with the law a vertical spiral type fire escape, large

The miners pay \$1.25 a month for doctor's care for themselves and their families. Since they do not have to pay a doctor's bill when hospitalized, this makes it easier to meet the hospital bill. The mines set aside \$0.50 a month per employee, also, for care of industrial accident cases. This is divided equally between the doctors and the hospital. Accident prevention programs in the mines, however, have made industrial accidents very rare.

The More Hospital is of wood construction and not particularly prepossessing on the outside. Inside, however, it is a beehive of activity. The clinic and hospital provide medical care to miners and their families on the basis of a monthly payment.

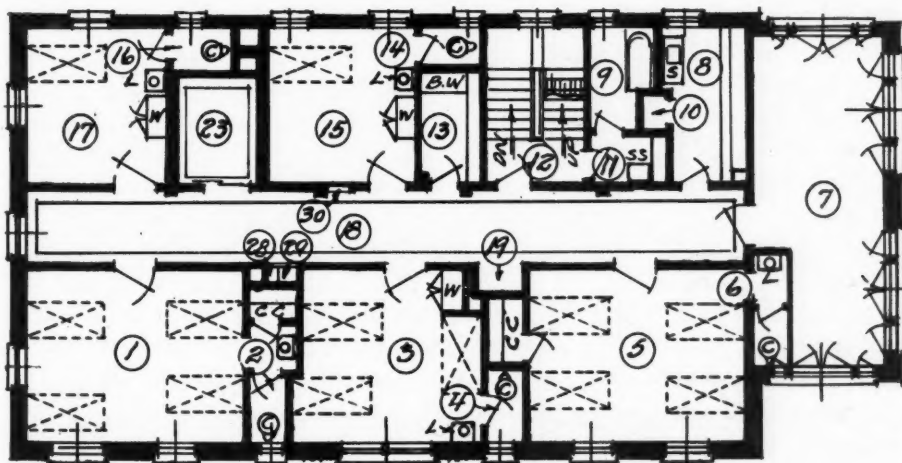


enough for a patient on a mattress, is now in course of construction, automatic door entrances to this being from the solariums on the second and third floors. The installation cost will be \$1,500.

Most of the beds are in small wards, there being only four single rooms. Rates are \$2.50 a day for miners in the three and four-bed wards and \$4.50 in the private rooms. Other cases pay \$3 a day for wards, \$5 for semi-private and \$6 for private rooms. The delivery room charge is \$5, plus \$5 for dressings; \$8 covers the operating room fee and \$5 is charged for an anesthetic given by a nurse (somewhat more if gas is used).

As in most small hospitals, the personnel do not set rigid boundaries as to the type of work they will do. There is a great deal of helping each other in rush periods. The personnel numbers fifteen as follows: superintendent, office secretary, engineer-janitor, laboratory and x-ray technician, extra x-ray technician, five nurses, cook, kitchen maid, two floor maids and laundress. At full occupancy this gives but one-half person per patient, a ratio that can be satisfactory only when there is good cooperation between all personnel.

There has been much criticism in urban centers about the attitude of the federal government



Plan of second floor—(1) 4-bed ward; (2) toilet; (3) 3-bed ward; (4) toilet; (5) 4-bed ward; (6) toilet; (7) solarium; (8) diet kitchen; (9) bathroom; (10) dumbwaiter; (11) utility room; (12) stair hall; (13) linen and blanket room; (14) toilet; (15) private ward; (16) toilet; (17) private ward; (18) corridor; (19) nurses' station; (28) soiled bandage chute; (29) soiled linen chute; (30) hose cabinet.

towards hospitals. In the Stambaugh hospital and in others on the Iron Range, only words of praise are spoken about the benefits to these institutions of having CCC boys as patients. Without the extra income from these boys, several of the mining company hospitals would have been in the "red." The government pays \$2.50 a day plus extras.

Last year the hospital cared for 476 adults and 63 new-born infants. This year the patronage has nearly taxed the hospital's resources. While the accommodations can be stretched to admit thirty-five adults, the officers of the hospital must soon consider the possibility of an addition.

We Reach a Jumping Off Point

Moving farther west on the Iron Range we come to Ely, Minn., northeast of Duluth. One reaches it by driving along the beautiful north shore of Lake Superior and then turning north through the Superior National Forest.

Ely, even more than Stambaugh, is predominately a mining town, although it is also a favorite jumping off point for fishermen and hunters going into that section of northern Minnesota where all travel is by canoe. The first iron ore was mined at Ely from the old Chandler mine in about the year 1888.

Dr. Charles G. Shipman who had previously been in mining practice at Ishpeming, Mich., and then at Bessemer on the Gogebic Range in Michigan, was the pioneer physician on the Range and came to Ely in 1888 as the mining company's doctor. In 1893 he built the Shipman Hospital. Dr. George T. Ayres and Dr. O. W. Parker, the present owners of the hospital, were originally his assistants, buying him out at the time of his retirement. It is the only general hospital in Ely.

The Shipman Hospital combines in one building offices for the two owner physicians and their associate, Dr. H. N. Sutherland, a residence for Doctor Parker, and hospital facilities for their patients, which include not only miners but also a considerable percentage of the town's other residents, the farmers in surrounding communities, CCC workers, tourists, and the railroad men of the Duluth, Missabe and Northern Railway Company at Ely. Probably about one-half to two-thirds of their work is for the miners who have a wage check-off similar to that in Stambaugh.

The hospital itself is of wood construction and has the appearance from the outside of a large residence. It stands on a prominent corner in the center of Ely opposite the city's beautiful new city hall. On one side of the hospital is a large old-fashioned garden with iris, various evergreens, including Colorado blue spruce, a clump

of Linden trees, Lombardy poplars, lilacs, peonies, bridal wreath and many other flowers and shrubs. A low hedge surrounds the garden which does not cut off the beauty from passers-by. A row of American elm trees surrounds the hospital grounds at the sidewalk. These plantings have all been made by the owners of the hospital.

The hospital is equipped with fire extinguishers on each floor and in the basement. Also there is a special fire alarm direct to the fire department which is just across the street in the new city hall. Fire escapes for each floor are provided. The building is heated by an oil furnace with automatic thermostatic control. The kitchen is provided with an electric range and electric refrigeration. The laundry is electrically equipped with an electric washer and electric ironer.

The hospital, in addition to regular equipment for x-ray work and for surgery, has a well stocked drug room and an oxygen tent for the service of the community. A new portable x-ray unit of the latest type has recently been added to the x-ray service. The capacity is fifteen to eighteen beds, with three bassinets. It has a fracture bed of the latest type with a full line of equipment for treating all fractures both surgical and by traction methods. The beds are equipped with new, thick, heavy mattresses of the latest type for comfort and rest.

Each Maternity Patient Has Special Nurse

The regular staff includes one nurse who does laboratory work and three assistants who are not graduate nurses but are trained in practical nursing, one secretary-bookkeeper, one male technician for x-ray work who also does orderly work and drives the ambulance and does general work around the hospital, one cook, one kitchen maid, and one laundress. Special nurses are called in as needed either to take care of private patients or to do floor duty.

Each obstetric case has a special nurse during the first twenty-four hours. A new ambulance within the last year has been put into service and is equipped with the latest type of Bomgardner cot with pneumatic rubber tires.

Occupancy in the hospital suffered somewhat during the depression, but is now coming back, with more work in the mines, more tourists, and the advent of the CCC. The birth rate in Ely has gone down considerably in the last few years. Before the war the doctors delivered about two hundred babies a year. During 1935, there were ninety-six births and of these thirty-seven were born in the hospital. Miners are given a flat rate of \$15 for maternity cases and \$5 a day for hospital care. Many women stay only one week.

Complicated laboratory work is sent away to larger laboratories or to the state board of health in Minneapolis. This includes such examinations as typhoid, tularemia, undulant fever, Wassermann's and spinal punctures. The simpler tests are done at the hospital. Some blood chemistry is done such as for urea, creatinine and blood sugar.

Doctor Parker feels that there are distinct advantages in the wage check-off system for paying for medical care for these mining families. Physical examinations are given to all the miners at time of employment and to many of them annually thereafter. The miners and their families feel free to come to the hospital for all kinds of service from treatment of the most minor things, such as small injuries, cuts, bruises, removal of ear wax, eye infections and minor illnesses, to the most serious diseases requiring complicated medical treatment or major surgery. Everything is done to facilitate the early treatment of injuries and diseases, probably in the case of injuries preventing many serious infections and thus entering the field of preventive medicine and surgery.

Doctor Parker has been health officer of Ely for twenty-six years, perhaps the longest continuous health service of any health officer in the state. Associated with him is Dr. John Thompson, veterinarian, who has charge of the city laboratory and who does water, meat and milk inspection. Ely has a first-class water supply from Burntside Lake with a new modern treatment plant where the water is filtered and chemically treated. The sewage also is partially purified by means of an Imhoff tank.

Successful Preventive Work Carried On

As a part of his duties as health officer, Doctor Parker has charge of the contagious disease hospital of sixteen beds. This hospital is new and modern in every respect and is approved by the state board of health for the control of contagious disease. A matron stays there regularly and day and night nurses are called in as needed. The city provides free care for city contagious disease cases here. There are approximately two thousand school children in the Ely district of which about 90 per cent or more have received diphtheria toxoid for prevention of diphtheria at no expense to the parents. As a consequence of these preventive measures, Ely has been free of diphtheria for a number of years.

Another interesting aspect of the public health work carried on in Ely is the tuberculosis clinic conducted six or more times a year by Nopeming Sanatorium, the St. Louis County institution under Dr. Arthur T. Laird, who has a very advanced

program in the handling of tuberculosis. Tuberculosis clinics are also held at other Range towns either by Doctor Scherer, whole-time county health officer or someone from Doctor Laird's staff at Nopeming.

The doctors on the Iron Range have their own Range Medical Society and are in addition members of the county medical society. Both of the owners of Shipman Hospital and their associate are members of their county and state society and of the American Medical Association, as are practically all the doctors on the Iron Range.

Shipman Hospital, while not a modern fire-proof building and not comparable with the modern fire resistant building in Stambaugh, is nevertheless well equipped with modern fire protection and modern facilities for taking care of the sick and it renders a real service to the people in and around Ely.

Miners Buy Hospital Care

From Ely a short drive on a sparkling morning brings one to Soudan, where Dr. C. Gordon Watson has the Soudan Hospital. This is a smaller institution than the Shipman Hospital and Doctor Watson does not maintain a regular hospital staff, but calls in nurses as they are needed. He serves an area containing 2,000 to 2,500 persons. There are between 200 and 300 mining families who make the usual \$1.25 a month payment for medical service and buy their hospital care as they need it. In addition the mines pay \$0.60 a month per worker for industrial accidents.

Doctor Watson has been on the Iron Range less than two years but this past summer he spent two months in Vienna in a combined holiday and post-graduate tour.

Fortunately the kind of ore mined in Soudan has a steady market and the mines there continued in operation at nearly normal capacity during most of the depression.

Doctor Watson is not enthusiastic about the wage check-off method of paying for medical care. "At times," he says, "the demands on the contract physician may become quite heavy. He must judge carefully during such periods as to which cases are really in need of attention and should be given thorough examinations. There are always certain individuals who impose on this arrangement, but for the most part by tactful handling they can be trained to regard their physician much as one would in private practice."

Unlike the situation in Ely, the hospital building, which also is Doctor Watson's home and office, is owned by the Oliver Mining Company, a subsidiary of the United States Steel Co., and the equipment is owned by the doctor.

The next stop on this tour is the More Clinic and Hospital at Eveleth, Minn. Dr. C. W. More, the founder and owner, is a charming host and patriarch of the Iron Range. He graduated from the Chicago Medical College in 1888 and came to the Range shortly thereafter.

Busy as Bees

The More Hospital of wood construction is not particularly prepossessing on the outside. But inside it is a beehive of activity.

The ground slopes away sharply to the rear and advantage has been taken of this fact to build the out-patient department on a lower floor of this back section with an entrance at street level. At one o'clock on an ordinary June afternoon the large waiting room is full of people coming to the four doctors who now constitute the staff of the clinic. One other doctor is employed on part-time by the clinic to care for its patients in an adjoining town. Last year patients made 42,500 visits to these five doctors for services ranging from treatment of a mild burn to the most complicated surgical intervention.

The clinic and hospital not only provide medical care to the miners and their families but also on the same monthly payment basis to city and school employees on their insistent demand. Most of the doctors' work is done in the hospital since the people of Eveleth and surrounding towns have learned that they get better care by going to the hospital than by asking the doctors to come to their homes.

Doctor More is a firm believer in good nursing care. Only graduate nurses are employed in the hospital and he pays them from \$81 a month up.

The present hospital was built in 1900-01 and various additions were constructed at later dates. It now has a capacity of thirty beds and seven bassinets. While it is all of wood construction, fire extinguishers and fire hose are placed at frequent intervals. Furthermore Doctor More has devised a sprinkler system for the roof.

G. H. Murray is business manager for both the clinic and the hospital. He does the purchasing, directs the bookkeeping, handles the collections and makes up budgets and financial reports.

The balance of the staff consists of seven nurses, two laboratory technicians, one x-ray technician-stenographer, three stenographer-bookkeepers, one information and clinic clerk, two maids, two janitors and the usual laundry and kitchen help.

Full typewritten histories are kept of all cases, which accounts for the number of stenographers.

Private rooms cost \$5, semi-private rooms \$4.50 and wards, all of which are small, \$4 a day.

Contract practice, in Doctor More's opinion, is

highly desirable for the lower-paid workers. It provides them with a quantity and quality of medical service that they would never achieve if they paid for each service as it is rendered.

Our last stop on the Iron Range is the Rood Hospital at Hibbing, Minn. This is the finest hospital of them all, in point of building, equipment and number of personnel. In bed capacity it is not much larger than the hospital at Stambaugh, there being room for only thirty-five adult patients.

The ground floor is devoted entirely to doctors' offices, the business and administrative offices, the laboratories, the operating room with its accessories, the emergency department and the kitchen. The operating room and emergency department are close together and many facilities can thus be used in common. The laboratories, both clinical and x-ray, are extensive and well equipped.

On the second floor are patients' rooms. The third is devoted to maternity patients, with labor and delivery rooms and quarters for the help and the resident doctors. One end of the building is cut off on both the second and third floors to provide quarters for the all-graduate nursing staff.

The hospital was built in 1921 by the Oliver Mining Company and is leased by Dr. S. S. Blacklock and his associates. In 1935 the hospital had a daily average of twenty-two in-patients. There were 133 births there during the year.

One unusual combination of duties is found in Rood Hospital, namely, a dietitian who is also a laboratory technician.

It is apparent from this informal survey that hospitals on the Iron Range vary widely in size, equipment and modernness of facilities. One cannot make such a tour, however, without coming away with the belief that in general the miners and their families are receiving care that compares favorably with that provided for other workers of similar income groups in large cities.

Let Your Lawyer Help

Don't argue with a lawyer. He has made a special study of the law and presumably knows his law as well as you know your hospital administration. Show him the respect of consulting with your hospital attorneys before answering his letters. Besides, this may save you considerable difficulty with the subject of your correspondence. We suggest that you forward letters sent to you by attorneys to your counsel, giving him all necessary explanations, letting him reply and, if necessary, continue the correspondence. When you speak of protecting the interests of the hospital, this is one way of doing it, and the safest way that we know.—*E. M. Bluestone, M.D., Montefiore Hospital, New York City.*

Administrative Case Histories

THE administrator is guided in making decisions in difficult problems by the effect his decision will have on the care of patients and on the good name and organization of the hospital. These are the cardinal factors that guide the well trained hospital administrator in reaching a decision, regardless of whether the question relates to the purchase of expensive laboratory apparatus or to the giving out of information concerning patients.

By J. B. HOWLAND, M.D.
and N. A. WILHELM, M.D.

1. Admitting Patients

A local family physician called the admitting officer seeking to have entered a youth of twenty, so acutely ill with nephritis that he was *in extremis*, a fact readily admitted by the family doctor. Permission was refused, because, in the judgment of the admitting physician, the patient's life could not be saved, and therefore the expense of sending the ambulance and admitting a patient about to die was not justified.

At morning conference it was pointed out that from a dollar and cent standpoint, the admitting physician was correct, but from the angle of the family, their physician and the good name of the hospital, the decision was wrong. Death is a tragic thing under any conditions, but it is especially so in the case of the young. Had this patient been brought to the hospital, the family would always have felt satisfied that everything possible had been done to save him. Moreover, death would have taken place in the quiet and privacy of a hospital room, the family would have gone home spared the painful duty of preparing for the arrival of the funeral director. It must be obvious to anyone what a kindly feeling would have been felt toward the hospital by both the family and their physician.

Naturally, cases come to mind where quite the opposite reaction would exist, families even blaming the hospital for an expected death or insisting on removing the dying patient to their home. These cases, however, represent that fast dwindling class of people who distrust and fear the hospital. Certainly in instances where the family requests entrance to a hospital for an expiring member, it should be granted regardless

of whether the patient has but a few hours or a few days to live, regardless of whether the hospital is paid or not. The hospital exists to serve the people of the community, and while the staff may frown or even oppose accepting such cases, because it increases the death rate or because there is no teaching value, nevertheless, it is the clear duty of the hospital to furnish terminal care.

All too often, pressure is brought to bear on the administration to restrict admissions to the public ward to cases that are of scientific interest. Elderly patients with common or not particularly interesting cardiac conditions, patients under that horrible suspicion of being neurotic, and many other types of patients whose disease is not particularly interesting and upon whom no dramatic cure or diagnosis can be made, would in many instances and in too many hospitals find considerable difficulty in securing admission if certain staff members were permitted their way. While such a tendency always exists *sub rosa*, it is one of the most pernicious things the hospital administrator has to guard against. If a hospital is founded and supported purely as an adjunct to a medical school, that is one thing, but if it is founded as a charity we must ever bear this fact in mind, and not be persuaded to rule against patients who may not be the best of teaching material.

2. Emergency Patients

A young wife was brought by ambulance to the hospital as an emergency. The frantic young husband arrived almost at the same time by taxi having been summoned from work. The patient was properly cared for and sent to the public ward, but the upset husband was kept waiting his turn in the lobby until the admitting physician could see him.

The patient was eventually discharged cured, but the following week a letter arrived from the

husband, an intelligent person, criticizing the hospital for the manner in which it detained him on the day of his wife's entry. He pointed out, and all too clearly for comfort, that regardless of the fact that while the admitting physician knew the patient was in good hands, he, the husband, did not know. Moreover, he was terribly upset by this sudden blow and in no frame of mind to be questioned on such necessary but irritating statistical data as the age and maiden name of his wife.

Why, he argued, wasn't he permitted to go directly to his sick wife to see with his own eyes that she was handled gently by attendants, that she was safely in bed and in the able hands of doctors and nurses. Then, with much more calmness and peace of mind, he would have returned to the admitting physician and answered necessary questions.

This very sound letter was taken up at morning conference. The admitting physician stated that from his viewpoint the most important job had been done and well done, namely, the patient, who was the one most concerned, had with neatness and dispatch been cared for. The job of the hospital, after all, was to take care of the sick not the well member of the family.

Here again is seen the importance of viewing the problem from the larger aspect of what is the effect on the hospital as a whole. From a narrow standpoint, the judgment of the admitting physician was correct, but from the broader point of view, the criticism was a just one. A hospital is obliged to render every assistance possible to the distracted relatives for while, truly enough, it is secondary to the care of the sick, still it is a necessary part of the hospital's work.

3. Care of Valuables

There are various systems of handling valuables and clothes but all have the same objective—to protect the patient's goods from loss by carelessness or theft. All hospital administrators know, and any patient with even the slightest imagination can readily understand, that the responsibility of caring for patients' clothes and valuables is no small matter.

A bed patient was suddenly nauseated and vomited, during which he lost his false teeth. The nurse emptied the vomitus, and with it, the teeth. A demand was sent to the administration that the plates be replaced at the expense of the hospital. Investigation showed that the patient was neither comatose nor semi-comatose, and accordingly was in a position to warn the nurse he had ejected his

teeth while vomiting. This he failed to do, and certainly the nurse could not have been expected to suspect such a situation. Moreover, the patient, with full knowledge, signed a slip taking complete responsibility for all retained clothing and valuables which specifically mentioned false teeth. Accordingly, the hospital denied responsibility and the claim was refused.

Recently, there appeared a relative of a former patient who died in the hospital and who made claim for an expensive bed jacket. A careful search did not result in finding the article, and further checking revealed that the clothes listed, checked and signed for by the undertaker, did not mention the bed jacket.

Confronted with this, the relative stated that the jacket was brought in by another member of the family. The clothes list signed by the patient states, "I take entire responsibility for retaining in my own possession the following articles (patient writes out: glasses, wedding ring) as well as any which are brought in to me subsequent to this listing." Accordingly, responsibility was denied and the hospital declined to make restitution.

It must be obvious that no hospital could be held responsible for articles brought to patients by visitors unless the patient acquaints the nurse in charge with such facts.

The valuables should all be listed in a book which permits the original to be given to the patient as a receipt, and the carbon copy remains in the book, becoming a permanent ward record. Great stress is placed on the importance of accuracy for the protection of all concerned. After the listing has been made, the patient and nurse who receives the valuables, sign on their respective lines, the original is detached and given to the patient, while the book containing the carbon copy, and the valuables, are taken promptly to the cashier's office. The nurse makes herself liable for the valuables from the moment she accepts them until they are deposited in the office.

The cashier makes out a duplicate list on a card which is filed, and then signs the book brought by the nurse, thus furnishing the irrefutable evidence that she received all goods listed. The articles are then placed in the safe until the patient is discharged, whereupon the cashier's card is signed by the patient for the safe and complete delivery of all valuables.

Should the patient wish any of the deposited valuables, such as money while still in bed, the nurse secures from the cashier the card previously filed containing the listing and marks "Receivedfrom above property" and sends it to the patient who signs the card. The nurse then returns with the card, receives the property and

takes it to the patient. Here again, she is liable for the property from the cashier's office to the time of actual delivery to the patient.

The handling of clothes follows about the same procedure. Here, a triplicate system is used, which allows a copy to the bookkeeper and patient, and the third is left bound in the book as a permanent ward record.

4. Information Concerning Patients

The demands made on the hospital for information of all types calls for nicety of administrative judgment. These requests vary from relatives seeking information regarding patients to demands by the press to photograph some prominent individual. The handling of any request is purely an administrative matter and must be controlled by the administration. Exceptions are made only by the superintendent.

John Doe was admitted, and being a person of national fame, the press at once demanded information as to his general condition and whether an operation was contemplated and insisted on permission to photograph the patient in his room. All these requests were courteously but firmly refused. No attempt was made to deny the presence of the patient, but the press was told the physicians would issue bulletins as they saw fit.

Permission to make photographs was not even considered. It is the duty of the hospital to protect its patients from all such requests. However, this particular individual had no objections to being photographed, and, on the contrary, desired that it be done. Permission was refused, nevertheless, for it now became a matter of policy and to take photographs of patients in bed in a hospital is, to say the least, bad taste.

Having recently installed a new heavy duty kitchen range, the administration was requested by the manufacturer for permission to photograph the hospital which would then be reproduced in advertising columns, with the all too familiar caption, "The Hospital where Nev-Bus ranges render satisfactory service."

All such requests should, as a matter of policy, be flatly refused. After all, a hospital should be known for the good work it does and not because it uses some particular equipment. The more ethical way to handle such matters is to permit salesmen to state to prospective buyers that they may write to the hospital and that inquiries will be cheerfully answered as to the satisfaction their merchandise is rendering. At Peter Bent Brig-

ham Hospital, any salesman is at liberty to state to another hospital that we are using his product and that we will answer inquiries relative to it.

Requests for information from clinical histories are often a source of annoyance. Insurance companies and attorneys are aware that to secure a copy of a patient's record, the written permission signed by the patient, or, if deceased, by the closest relative, is necessary. But the annoying part is their request that records be abstracted. Presenting the properly signed permit, an insurance company asked for a copy of a clinical record. The case was a brain tumor with an unusually long record, and the estimated cost for copying was \$15. The insurance company was indignant at the amount, and refused to approve of a copy being made. However, they needed the data and the administration was petitioned to abstract the lengthy record, thus giving them the essentials and reducing their expense. This request was refused.

Abstracting records which are going to insurance companies or attorneys is a source of potential trouble. No one but a physician can intelligently abstract these long complicated case histories and to pay a physician for the time spent would probably equal the cost of making a complete copy. Moreover, the medical department of an insurance company is certain to want additional information from facts gleaned in the abstract. This results in more correspondence and, inevitably, in irritation to both parties. It is a wise policy to refuse to abstract case histories except for family physicians, other hospitals, or fellow charities.

Administrators are frequently called upon to tamper with certain facts in patients' records, and sometimes pressure is brought to bear that some necessary changes be made. Here, there can be but one policy—an absolute refusal to permit a record to be changed once the record has been completed, approved by the chief of service and filed in the hospital library.

A former patient appeared with his signed permission to issue a copy of his record to an insurance company to which he had applied for a policy. However, he recalled that in giving his history to the house officer, he admitted having had a venereal disease. The insurance agent was a personal friend and would see his medical record. Would the hospital be willing to leave that information out? The hospital refused to grant the request.

A series of case histories should be the material for a "Precedent Book" and such books in all departments are most helpful as charts for steering the hospital on a definite course.

What Others Are Doing

The Girl in the Smock Will Help You

If, as you walk into the Western Pennsylvania Hospital in Pittsburgh, a young woman in a smock approaches you with a "May I help you in any way at all" expression on her face, you can safely relax and know your worries are over. You have been temporarily adopted by a member of the Junior Committee.

Many years ago the first group of junior volunteers was organized. These girls were stationed in a receiving line as hostesses. Their willingness invited more responsibility. Student nurses gradually surrendered minor duties to the volunteers, who now do a considerable variety of hospital work.

The Junior Committee operates somewhat as a club. Its membership is limited to seventy-five and new volunteers come in by nomination. Their working hours are in the morning, the hospital's busiest time, and they appear with salary earning regularity.

Their duties are legion. They carry messages; they read letters and books to the sick; they talk to lonesome patients; they write letters; they help to guide and roll occupied beds from different parts of the hospital; they roll bandages; they remind clinic patients of their appointments; they do filing, and, on the operating room floor, they are the connecting link between the surgeons and the rest of the world.

Guy's Hospital Shop Shows Real Profit

Guy's Hospital, London, several years ago started a small shop to dispense tobacco, sweets, toilet necessities and other things that patients might like to buy or their visitors to buy for them. The shop also supplies coffee, tea and nonalcoholic drinks to any person in the hospital who wants to buy them, and sends a selection of goods on a trolley through the wards every day to stimulate sales.

The accounts of the shop for the year ending December 31, 1935, showed a profit for the year of £587.16.3. On January 1, 1935, an inventory showed that the shop had £301.12.0 worth of goods on hand. During the year purchases amounted to £2,228.12.9. On December 31, the goods on hand amounted to £274.7.0,

the cost of the goods sold amounting to £2,255.17.9.

Salaries and allowances to the staff, repairs, electricity, gas and water, cleaning, rates and rent amounted to £395.17.2. The total receipts for the year were £3,239.11.2. Gross profit on sales amounted to 30.4 per cent and net profit on sales, 18.1 per cent, an improvement in the first of 6.4 per cent over the preceding year, and in the second, of 3.7 per cent.

Equipment Rental Service for Home Patients

The home patient at Berkeley, Calif., will no longer have to use makeshift equipment or purchase at tremendous cost those pieces of hospital equipment that would add to his comfort and his healing. The Berkeley Hospital, of which Alfred E. Maffly is superintendent, has instituted a rental service for the benefit of these persons. Among the equipment now available to be rented are hospital beds, fracture beds, Ford beds, mattresses, Balkan frames, Bradford frames, back rests, folding bed cradles, wheel chairs, bedside tables, crutches, bedside equipment and a stock of splints.

That the Patient May Record His Progress

As he walked through the Hospital of St. Barnabas and for Women and Children, Superintendent John G. Martin continually noticed the dozens of greeting cards, the vases of flowers, the visitors in each patient's room. He saw about him friendships being made between patient, nurse, doctor. He regretted that these pleasant things lasted only as long as the short memory of the individual, and having seen and regretted he decided to do something about it.

"My Comeback" was what he did. This is a thirty-two-page booklet, bound with a light blue stiff-paper cover. Black and silver are used in a decorative three-line border down the left hand side of the cover. The title

of the book, "My Comeback," is printed in plump, comfortable looking silver letters outlined in black. A reproduction of a marine painting appears on the cover.

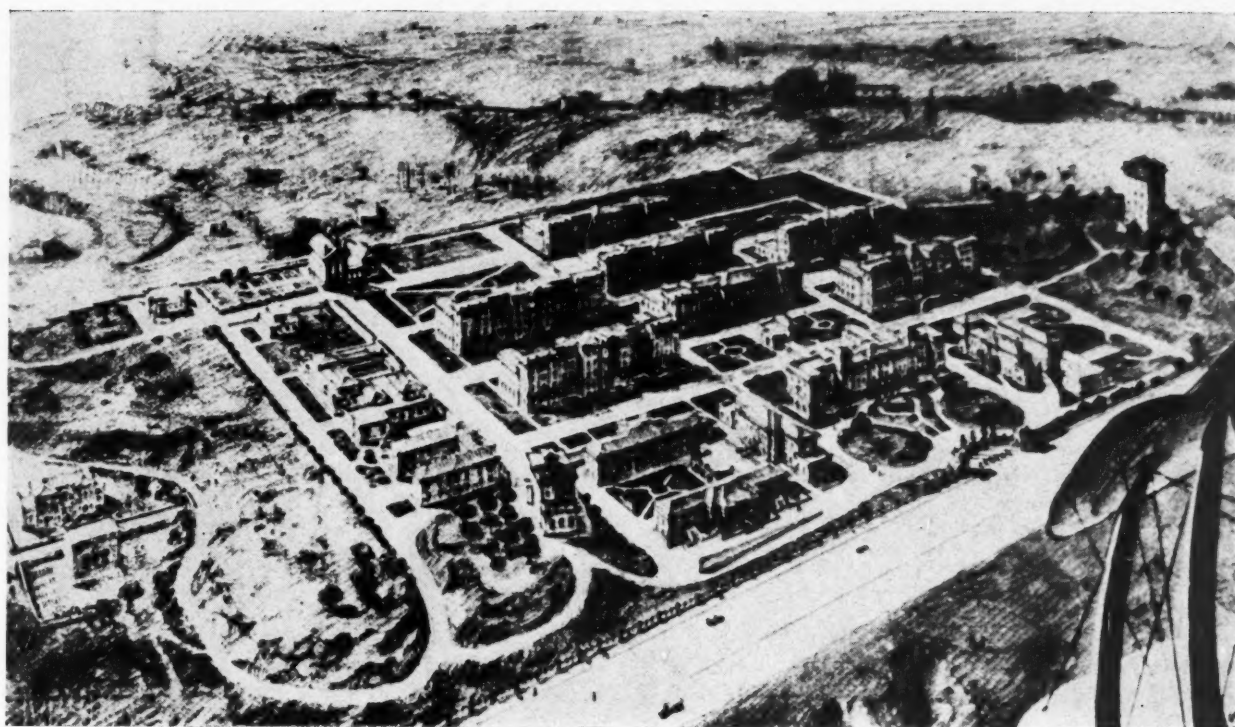
The book serves a dual purpose. It is a record of the patients' hospital stay and at the same time is of value from the standpoint of occupation and diversion. One page is devoted to "The Event," another is entitled "Important to Me" and records an accident history; other pages provide for a record of daily progress, amusing incidents, visitors, flowers, greeting cards, letters, telegrams, books, personal memoranda, telephone inquiries, and addresses to remember.

During its planning it was decided by Mr. Martin and the publishing company, after consultation with other hospital administrators, that its use should be extended beyond the use of his hospital. This permitted the printing of a more artistic book which costs twenty-five cents to produce. It is being distributed through the agencies of the New Jersey Hospital Association. At the Hospital of St. Barnabas and for Women and Children, members of the senior nursing class sell the book for fifty cents to raise the funds required for the publication of the annual class book, "White Caps."

Lesson "One" in Hospital Economy

Again Brokaw Hospital, Normal, Ill., occupies the center of the stage, but the scene now changes to the demonstration room where the student nurses receive practical instruction in the care of the patients. On the bulletin board are four charts upon which have been mounted cut-out pictures of hospital equipment with the price of each clearly indicated. One of these is labeled "Glassware Costs," another "Enamel Costs" the third "Costs of Rubber Goods," and the fourth contains miscellaneous items. The hospital goes on the assumption that it is just as well to let the students know the value of the articles entrusted to their care. Lest the novelty of the display wear off and come to be regarded merely as classroom decoration, the charts are removed when it is felt that lesson "one" has been thoroughly assimilated.

Probably you can think of one or more practical ways to save time or increase efficiency. The Modern Hospital will welcome your ideas to put before other hospitals



On a Roman Hill

By NATALE COLOSI

FEW greater monuments to scientific medicine have been built anywhere than the Ospedale del Littorio, recently completed in Rome. The hospital is a consolidation of several old and glorious institutions, among them the Ospedale di S. Spirito, founded in the year 1200, the first hospital built by Christianity, the Polyclinic, St. John's and St. James' Hospital and the Hospital for Chronic Diseases.

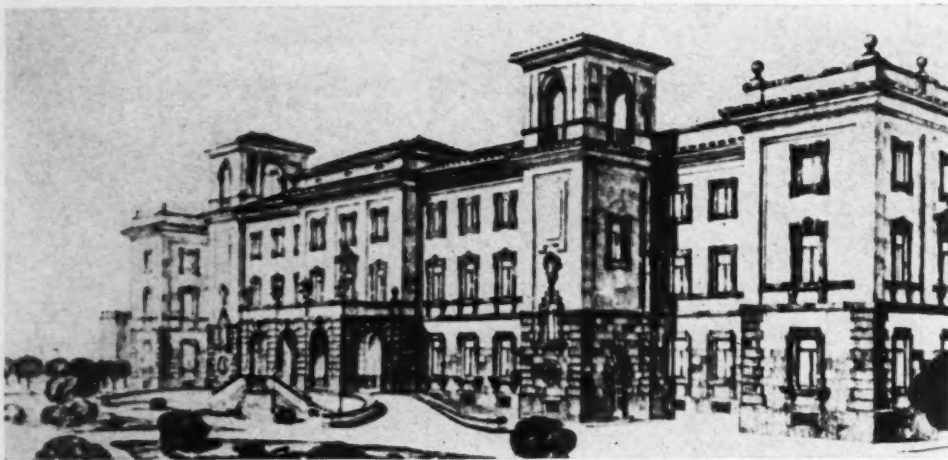
The need for a hospital worthy of the capital of Italy has been felt since the rapid increase of the population of Rome rendered the city's hospital service inadequate. In 1919 projects for a new hospital were made and the corner stone laid. Not much progress, however, was made in the construction of the new hospital, and the plan was abandoned until soon after the advent of Fascism when work was resumed and the buildings completed within twenty-five months at a cost of 42,000,000 lire.

Situated on one of the most beautiful hills of Rome, the Monteverde, the hospital resembles an immense, luxurious villa surrounded by gardens and flowers. Thousands of birds sing festively

under the ward windows in the warmth of the postmeridian sun. From the windows one can see the city of the Caesars, the historic Tiber, the Aventine, the Portuense Parkway, Villa Pamphili, St. Peter's Cathedral, St. Paul's Basilica, the parks of eucalyptus, most of the

Roman Campagna and the Albani Hills. The new hospital meets the requirements of the Italian concept of a hospital which includes the idea of space, air, sunshine, tranquility, and every physical as well as spiritual comfort in a place remote from noise.

The vast hospital city is comprised of several buildings and has a capacity of 1,500 beds. There are seven pavilions or buildings, three medical, three surgical and one for specialties. There are thirty-four large and fifteen small wards, including those for the isolation of contagious cases; spacious operating rooms; buildings for the resident staff; a chapel and refectory for the Brothers to whom is entrusted the spiritual care of the patients; a morgue; laboratories of bacteriology and pathology; pharmacy and drug rooms; sterilization rooms; power house; kitchen, and garage. The separate buildings of white gravel offer an artistic contrast to the green of the surrounding gardens, giving the impression of a sixteenth century villa rather than of a hospital. The immense grounds are surrounded by a wall. It would be difficult to describe in a brief article the equip-



The administration pavilion of white gravel offers an artistic contrast to the green of the surrounding gardens, giving the impression of a 16th century villa rather than a hospital.

ment of the hospital, but a succinct description can be attempted.

The emergency service occupies one building. Here are several medication rooms; beds for slightly injured patients; offices for the personnel of the department and attached police officers; an operating room; an x-ray laboratory, and several sterilization rooms. Two wards, one for men and one for women, with special small wards for probable infectious cases, offer facilities for brief hospitalization. After twenty-four hours, patients who will require protracted hospitalization are transferred to other wards by means of noiseless electric carriages.

Three Identical Medical Pavilions

The three spacious medical pavilions are identical, well ventilated buildings. Each floor is divided longitudinally by a corridor which receives an abundance of light from two large windows at the extreme ends and from several other windows opening on intersecting corridors. There are three sections to each floor, one central and two lateral. Off the central section are the stairway and four elevators, one for the exclusive use of the personnel, two for patients and one for freight. On each floor are visiting rooms; a laboratory for minor clinical examinations; a room for the resident physician; a room for the assisting personnel where patients' calls are received by an electrical signal system; a kitchen; refrigerators, and rooms with modern equipment for washing and sterilizing.

In the lateral section are two isolation rooms and a large room for patients who are not confined to bed and eat their meals at table. On each lateral side is a veranda where patients may enjoy the benefits of air and sunshine. The wards are well ventilated and not congested. A roof garden affords to convalescent patients a view of the panorama of Rome, with its fountains and hills.

The three surgical pavilions are similar to each other in structure. Each pavilion consists of four floors, and the partition of wards and the service rooms are similar to those of the medical buildings except that there is an extra elevator for the exclusive use of patients being transferred to and from the operating rooms. The entire fourth floor is devoted to operating rooms with northern exposure.

Each unit has its own special departments for the preparation of the patient, narcosis and sterilization of instruments.

One entire pavilion is devoted to ophthalmology and otorhinolaryngology. Two dispensaries for these specialties are on the ground floor of this building.

Especially well equipped are the pavilion of radiology and physiotherapy.

The entire hospital city has fifty external and two hundred internal telephone lines. There is an emergency electric system connected to a central station, so arranged that it comes automatically into action should the regular electric system cease to function.

The hospital staff is composed of visiting physicians and surgeons who are assigned to duty following competitive examinations and upon meeting requirements as to experience and academic qualifications. The visiting physician or surgeon must always be ready for service upon telephone notification, unless the case can be taken care of by assistants or by members of the resident staff. In this manner immediate and competent hospital service is available day or night.

The members of the medical and surgical staff are salaried in proportion to their status. Service is rendered without charge to the poor, but an adequate fee is charged patients who can pay. The hospital is easily reached by railway, street car, bus line or automobile, a cement road having been built leading directly to it.

Associations Set 1937 Tasks

Progressive plans are being pushed by the presidents of the leading associations in the hospital and related fields and readers will find much to interest them in comparing the various programs that are here presented

American Hospital Association

By C. W. MUNGER, M.D.



IT IS my aim, with the help and guidance of the board of trustees, to direct the association's activities toward eleven main objectives in 1937 as follows:

1. Continuance of activities and more adequate financing of

the work of the council of the American Hospital Association.

2. Aggressive activity in the guidance of existing plans for group payment for hospital care; encouragement of new plans where needed and active assistance in organizing them properly; vigilance in holding all group plans in line with what is best for members and for hospitals.

3. Studies of needs for facilities for convalescent and for chronic patients.

4. Investigation of possible values of a high grade hospital exhibit at the New York world's fair in 1939.

5. More active interest in international hospital affairs.

6. Studies of means further to improve the quality and content of that important part of medical education which is gained through hospital internships and residences. Guidance for hospitals which can comply with recently established training requirements of the medical specialty boards.

7. Furtherance of the cause of hospitalization

through all the legitimate channels of publicity.

8. Representation of the association in, and cooperation with related professional bodies such as organized medicine, nursing, dietetics, social service, anesthesia and medical recording. Following through on conferences already initiated, such as that on revision of the standard curriculum for schools of nursing.

9. Stimulation, when possible, of increased realization by hospitals of their potentialities and their responsibilities in relation to promotion of the public health.

10. All possible increase in association service to members, expansion of membership, and expansion when possible of sources of income to meet the costs of an increasingly valuable program.

11. Continued interest in training for the career of hospital administration; repetition of the institute for hospital administrators.

American College of Hospital Administrators

By BASIL C. MACLEAN, M.D.



AT THE 1936 meeting of the College in Cleveland, the fellows and members present at that meeting received the report of the committee on future program and policy. After considerable discussion and a number of amend-

ments, this report was adopted. It provides for a broadening of the membership structure and for the conduct of the College through a revised constitution and by-laws. A bulletin will be issued periodically as a means of keeping the membership informed of all activities.

At the same meeting, the committee on training of hospital administrators presented a report which will be considered in greater detail by the board of regents in February, 1937. This report

proposes a plan for combined academic training and apprenticeship leading to a bachelor's degree and subsequently, after postgraduate study, to a master's degree.

On this question there will unquestionably be a diversity of opinion, for there are probably many who believe that a plan of collegiate training for the training of hospital administrators is not the proper approach to the problem. However, even those who lay most stress on the practical will no doubt agree that some pattern should be drawn for the training that is needed. The excellent work of the "Institute" during the past four years and experiments in collegiate training, as for example, at the University of Chicago, indicate that some more comprehensive plan is desired.

There is no magic or mystery in hospital administration, but if the management of a hospital is an occupational specialty, there should be some means provided for training in that specialty. During the past thirty years, hospitals in America have increased from about 1,000 to over 7,000 and hospital problems have increased proportionately. The first cry and the last sign take place in the hospital more often today than they did a generation ago and the hospital has acquired new relationships to the medical profession, to the community and to government.

The need for some change in the system of training for hospital administration seems obvious. This question is one which will probably receive most effort from the College during 1937 and it is hoped that in this direction our work will supplement that of other organizations.

American College of Surgeons

By MALCOLM T. MacEACHERN, M.D.



THE American College of Surgeons will commence its twentieth annual hospital standardization survey on January 1, 1937, with approximately 3,700 hospitals of twenty-five beds and over on the survey list. Of this number, 2,577

have already been approved by the College.

The major part of the 1937 survey will be confined to the Eastern and Southern sections of the United States with such additional work in the Midwest, West and Canada as is indicated. A close follow-up will be made on all hospitals pre-

viously visited to ascertain the progress they are making.

The following criteria will be of major importance in the rating of each hospital for the 1937 survey:

1. Efficiency and competence of the administration, with particular stress on the experience and training of the superintendent or director.
2. Professional and ethical qualifications of the individual members of the medical staff.
3. Organization of the medical staff and its control and supervision of the scientific work of the institution.
4. Scientific value of the medical records and the uses to which they are being put.
5. Quality of the medical staff conferences insofar as they furnish a thorough review and analysis of the clinical work.
6. Organization and use of the adjunct diagnostic and therapeutic facilities in the care of the patient.
7. Adequate and efficient nursing service.

In addition, special attention will be directed to compliance with the requirements in the care of obstetric patients, the treatment of fractures, and the promotion of follow-up work and the study of end results. Information will also be assembled on ambulance, out-patient, and pharmacy services.

American Protestant Hospital Association

By ARTHUR M. CALVIN



DURING 1937 the American Protestant Hospital Association will encourage its members and other hospitals directly or indirectly connected with churches to give serious consideration to the increased demand of the public for

better and for less costly hospital care, two demands which may lead legislators into some form of state hospitalization, unless the type of care requested is provided under some form of group hospitalization.

Another association objective for 1937 is to carry out a publicity program to acquaint the general public with the value of voluntary hospitals and the reasons for the cost of hospital care.

A third objective is to acquaint our denominations and members of our churches with the work

of the Protestant hospitals so there will be more contributors towards this form of philanthropy.

We propose to make a special membership campaign during the coming year, not only for the purpose of assisting and helping each Protestant and voluntary hospital but for the purpose of making our association strong enough to command respect by the legislators of our federal government. Through the joint committee of our three national hospital associations, we are preparing a large legislative program.

We are inaugurating this year a four-page bulletin which will be sent out bi-monthly to the members.

Council on Medical Education and Hospitals of the A. M. A.

By WILLIAM D. CUTTER, M.D.

SERVICES already being promoted by the council on medical education and hospitals of the American Medical Association, and others to be taken up during 1937 are:

1. Evaluation of medical education and classification of medical colleges.
2. Special attention to the training of interns and a re-survey of hospitals approved for that purpose.
3. Studies of residencies in specialties. Relation to the residency requirements of the several specialty examining boards and cooperation with and approval of such boards.
4. Investigation and approval of schools for laboratory technicians, physical therapy technicians and occupational therapists.
5. Greater efficiency in all of the council's functions through additional floor space and better facilities recently provided.
6. The annual census of hospitals, with statistics as complete and reliable as possible.
7. Scientific exhibits at annual meetings of the American Medical Association and related organizations.
8. The usual information and assistance to hospitals, the medical profession and the public in answer to inquiries.
9. Contributions to special fields of medical and hospital work through special issues of the *Journal*, such as the hospital number, state board number, educational number, clinical pathology number.
10. Continued cooperation with constituent state medical associations, component county societies and other organizations.

National League of Nursing Education

By NELLIE X. HAWKINSON



THE League has set for itself the following four major objectives for 1936-37.

1. To bring about continued improvement in nursing education. To achieve this purpose the League will: (a) continue its program of curriculum revision; (b) set up and make effective a plan for accrediting schools of nursing on a national basis; (c) seek to improve the preparation of both undergraduate and graduate students in such special clinical fields as psychiatric and pediatric nursing; (d) continue the study of nursing school records.
2. To cooperate further with organizations concerned with the care of the sick, the prevention of disease and the promotion of health, including the American Nurses' Association, state boards of nurse examiners, the American Hospital Association and other allied organizations. Special attention will be given to a study of subsidiary workers.
3. To strengthen the League's program of service through increased membership and improvements in organization, the plan is: (a) to bring the membership up to 5,000 members; (b) to foster educational activities in the states through the development of local leagues; (c) to promote closer cooperation with state leagues through program activities and through the formation in state leagues of committees similar to those of the national league; (d) to provide more assistance to state leagues through the field service of the League.
4. To continue participation in the study of community needs for nursing service and the development of an informed public opinion regarding nursing education. In this connection, the League plans: (a) to study jointly with the A. N. A. and the N. O. P. H. N. community needs for nursing service and how to meet them; (b) to consider ways of using the interest, stimulation and help of lay groups, particularly nursing school committees, to further progress in nursing education; (c) to cooperate with the Nursing Information Bureau in bringing to the attention of the public important facts which concern nursing education.

American Nurses' Association

By SUSAN C. FRANCIS



DURING the coming year the association will proceed with certain major projects originated in the past and will initiate work on new projects. Some continuing projects are:

(1) study of community nursing needs and registry development; (2) eight-hour day; (3) study of incomes, salaries and employment conditions; (4) federal nursing projects; (5) the nursing information bureau; (6) special field service to state associations; (7) Florence Nightingale International Foundation.

Committees have been appointed recently: (1) to study the question of placement service and vocational counseling as an activity of the association; (2) to work with the American College of Surgeons on minimum standards for nursing service in approved hospitals; (3) to work with the American and Catholic Hospital Associations to consider the place of the graduate nurse in the hospital.

In addition, the association is planning a more helpful advisory service to state associations.

The association and the National League of Nursing Education have joint committees which are giving attention to:

1. Staff education programs.
 2. A study of existing nurse practice acts to (a) formulate provisions which should be written into an ideal nurse practice act, (b) compile a more complete digest of laws affecting nursing, (c) develop an advisory service on legislation.
- Jointly with the National Organization for Public Health Nursing the association is studying health insurance and its implications for nurses.

National Executive Housekeepers Association

By GRACE H. BRIGHAM

FOR 1937 the association has three distinct objectives:

1. To study the code of ethics adopted at the 1936 convention and encourage each member to conform to it, because only in this way can we bring the ethical standard of our organization to the desired plane.

2. To carry out a broader educational program, because we realize that the wider the scope of our interests and the more definite our knowledge regarding the matters coming under our direct supervision the better we can meet the demands of our profession.

3. To promote greater interest in association work, because we know the great value of the friendly relations growing out of cooperative activities.

National Association of Nurse Anesthetists

By HILDA R. SALOMON



THE association will devote most of its time during the coming year toward the attainment of the following objectives:

1. Standardization of a curriculum for schools of anesthesia.
2. Appointment of a grading committee

to list functioning schools.

3. Establishment of a board of examiners for nurse anesthetists.

4. An educational department in our official publication, the *Bulletin*.

It has been recommended that schools of anesthesia whose graduates are to merit the highest rating by the association shall give to their students a theoretical and practical training equivalent to our curriculum and that the minimum standards be: (a) course should be at least six months long, preferably one year; (b) ninety-five hours of classroom instruction; (c) eighteen hours of practical operating room instruction; (d) at least 325 anesthesia cases during the course.

The next step is the listing of functioning schools of anesthesia. To do this means a thorough investigation of the size of the hospital and length of course; the number of anesthetics administered per year and the number of students in the group; the number of staff graduate anesthetists giving instruction in anesthesia; the anesthetic agents regularly used and the various anesthetizing machines and types of anesthetics.

The next goal we hope to reach during the coming year is the establishment of a board of examiners for nurse anesthetists. Eventually the real rating of the various schools of anesthesia

will probably be measured by the number of graduates passing the examination. We are now in the process of preparing a master set of questions. When plans are completed we shall ask the endorsement of the various national surgical and hospital groups.

Our *Bulletin* has a circulation of over 1,500. At various times many of our members, as well as hospital officials, have asked for information pertaining to anesthesia problems. We feel it essential to install in the *Bulletin* a definite section on educational problems for the benefit of those who cannot attend conventions.

American Dietetic Association

By LUTE TROUTT



IN 1937 the administration section of the American Dietetic Association hopes to serve the needs of the administrative dietitian in the hospital, the college, the school lunchroom or other food units by its studies on food con-

sumption, equipment, quantity cooking and personnel management.

The community education section is concerned with the problems involved in imparting sound nutrition information to the lay public.

A policy of decentralization is to be followed by the diet therapy section this year. This section believes that individual members and the states have contributions to offer which should be presented at the annual meeting. Case reports of particular dietary interest and diets, used in certain clinics, that may be new and interesting are among the suggested topics for presentation at this meeting.

The professional education section chairman will direct studies of the content of courses and methods of instruction in dietetics for professional groups whom dietitians are called upon to teach within the hospital.

One of the major activities of the American Dietetic Association during this year will be the inspection of training courses for student dietitians. A plan of training which takes into consideration the varied types of work required of the dietitian in the hospital has been formulated by the association. There are fifty of these approved hospital courses in the United States and Canada. In addition to these, three nonhospital

administrative training courses and two food clinic courses are also approved by the association. These institutions, with others now seeking approval, will be inspected during the coming year by the inspection chairman and the members appointed by state groups.

Advisory Board for Medical Specialties

By PAUL TITUS, M.D.

THE eleven certifying boards now functioning in the various specialties are conducting examinations at frequent intervals for the purpose of determining the qualifications of candidates desiring to be formally recognized and certified as specialists.

The boards are: American boards of ophthalmology, otolaryngology, obstetrics and gynecology, dermatology and syphilology, pediatrics, psychiatry and neurology, radiology, orthopedic surgery, urology, internal medicine and pathology.

An American board of surgery is now in the process of organization.

Because of their many common interests, these boards, together with representatives from the Association of American Medical Colleges, the American Hospital Association, the Federation of State Medical Boards of the U. S. A., and the National Board of Medical Examiners, organized in 1933 the Advisory Board for Medical Specialties, under the presidency of Dr. Louis B. Wilson of Rochester, Minn. It reports to and functions closely with the council on medical education and hospitals of the American Medical Association. It has been generously aided by the Josiah Macy, Jr. Foundation.

Its aims are to establish and maintain uniform educational standards among the special boards, and simultaneously to foster, encourage, and to a certain extent direct the establishment of graduate training facilities throughout this country.

Recently the American Hospital Association recommended (1) that hospitals study the purposes of the board; (2) that they seriously consider requiring future appointees to the chieftainship of specialty services (and to such other appointments as may be considered advisable) to hold a certificate; (3) that they consider when appointing junior staff doctors whether their earlier postgraduate preparation renders them eligible after due experience to apply for examination; (4) that those hospitals offering residencies fulfill the requirements of the advisory board.



Modernization Step by Step

ABOUT a year ago Asa S. Bacon, superintendent of Presbyterian Hospital, Chicago, decided to refinish certain of the rooms in his private pavilion.

These rooms were redone one at a time, a considerable part of the work being carried on by the regular hospital staff. As soon as each room was refinished, it was thrown open for occupancy and the demand has consistently exceeded the supply. There are now twelve of these refinished private rooms, one of which is shown here.

In this room the furniture is all in natural bleached oak with a light finish. This includes not only the bed but the mirror frame, dresser, lamp, tables and chairs.

Mirror tops are placed on the dresser and on the small bedside tables. Cream and gold colors predominate throughout; the leather on the chairs is cream-colored and even the telephone book has a special cover in cream and gold. The drinking set is also gold color. All fixtures in the bathroom are finished in chromium.

Another recent change at Presbyterian is shown in the picture to the left. Formerly this was merely an unattractive end of a hall. Now it is an inviting waiting room, obtained at modest cost.



What's Next?

Running a hospital is a tough job, according to this author, who enumerates his perplexities and thereby finds relief

By JOHN H. HAYES

IF YOU have tears, prepare to shed them now.

In re-reading this gloomy article a few days after preparing it I tried to recall what had happened to bring it about. It was not written on a blue Monday and I remember being rather healthy when I wrote it. However:

Running a hospital is getting to be a tough job; not that it ever was an easy one, but it seems that we are now in an era when everyone seems to think that we are doing things wrong and that we are not able to take care of our own affairs and need their help.

This will be an attempt to enumerate some of the difficulties now before us; difficulties that are not easy to overcome, and many that are going to change modern medicine with no benefit to the sick.

First: (and this probably cannot be helped) Cost of food and supplies. In this we are certainly not alone in our complaint. But we are not able to overcome these increased costs by increased rates to our patients, as do manufacturers, hotel owners and others. Our hospital rates are generally based on the low costs of previous years. They have become more or less standard, and if we did raise them probably we should not be able to collect them anyway. The Robinson-Patman bill has added to our worries and has taken from us what little advantage we have had in purchasing because we are charitable institutions.

"Give Us Shorter Hours—More Pay"

Second: The cry for increased salaries and shorter hours. There is no reason why hospital workers should work longer than others. There never was a good excuse for it, except "human service"; and perhaps we are in a changing world and cannot do anything about that either.

But, again, we are confronted with the problem of how to pay for it. Some of us rightly feel that hospitals, particularly in large cities should not give room and board to workers. Actually, when costs rise you are, unconsciously or otherwise, raising salaries; and in a receding price period

you lower them. Few actually appreciate the value of meals, room, laundry and sick care, except at much marked down prices. They feel that "it's there anyway, at no additional cost," and count only the cash shown on the pay check.

Some hospitals now have pay cafeterias on a nonprofit basis and sell meal tickets. It is much easier to compare salaries with those not in hospitals when this is done. But the matter of salary and work hour adjustment is a current and important problem.

Third: Loss of income on investments, from gifts and legacies. This is also to be expected and has been commented upon many times; but, like the weather, nobody can do anything about it.

Fourth: There was a time not long ago when all of us would have laughed if we were told that some day we should have to employ lobbyists and others for the purpose of combatting legislation aimed at or incidentally harmful to hospitals. But we are now doing it every year, nationally and locally.

Who starts it? Almost anybody, including doctors, nurses, lawyers and legislators. Bills relating to hours of labor, wages, rates to patients, limitations of medical procedures, taxes on hospital properties, regulations for technicians, regulations on the use of drugs, in fact in connection with almost every hospital activity, have been introduced and many have become law, few being to the advantage of hospitals.

The subject of taxation is a constant legislative threat to hospitals. Even cemeteries are often included; and the idea now is to tax the Quick, the Sick and the Dead. Some fun!

Fifth: Discontent of the medical profession. Hard times have been harder for the doctors, perhaps, than for anyone else. More people have used

the free clinics and ward beds. Doctors' bills never were paid on time and lately have not been paid at all in many instances or reductions up to 80 per cent have been sought. In many areas there is the problem of oversupply of physicians. There are not enough hospital positions for these men. The result is dissatisfaction in these localities and among these doctors. These dissatisfied men attend the medical society meetings (I am told that the others are careless in their attendance) and agitation starts.

It would be wrong to state that hospitals do not, in some manner and in different localities, affect doctors' incomes. But in general, and over all the years, hospitals have made it possible for doctors to expand medical practice and treatment. They are the doctors' workshops provided at a cost of many, many millions of dollars — a provision not accorded to any other profession. Doctors have made hospitals what they are. It would appear at times that a few would destroy their own handiwork.

To seek pay for ward and clinic work might be an immediate solution to some doctors' problems, but it would be a great stride toward state medicine, limitation of the use of hospitals by doctors and lowering of medical standards.

They Sold Themselves Into Bondage

Sixth: Nursing. Not many years ago a course in nurse training was akin to selling one's self into bondage. Not much education was required to enter; not much was acquired during training (except of a practical nature); and the hospitals had a lot of cheap help. I think that was when we established our rates to patients. But no one cares to see a return to that system.

However, why go too far the other way? Educators, state boards and others interested in nursing are now discussing two to four years of college before entering. Class hours and study and rest periods have been greatly increased and the result is an average of about three hours of practical work a day, for which hospitals provide room, board, laundry, uniforms, books, sick care, entertainment. There is nothing wrong with that, except that it costs the hospital about \$800 a year per student, and the sick and the philanthropic pay for it. It is distinctly education and a function of the state. We should not pay for it unless we are reimbursed. And unless we are paid for it we should have more to say about changes proposed.

The following is food for thought. Have you compared the present situation of any of last June's college graduates from four to six-year courses, to that of a recent graduate of your two

and one-half to three-year nursing course? Remember that the college education has cost anywhere from \$5,000 to \$8,000; the nursing course cost practically nothing to the student or her folks. I know a number of young engineers, architects and lawyers who have boasted to me that within one or two months after graduation they were earning \$90 to \$100 a month. We take on student nurses the day they finish their course at \$75 a month, plus the value of \$65 to \$75 in board and lodging, a total of \$140 to \$150 a month. They deserve it, but I do not think that nurses in general realize how well off they are by comparison.

Nursing is difficult work. Eight hours should constitute a day's work, and I think that all of us are trying to bring it about. But legislation does not pay for it, except in city and state institutions — and all of us eventually pay for that.

Seventh: Labor unions. Hospitals have been picketed. That's something else that we should not have believed a short time ago. There are interns' unions. There are even periodicals, throw-aways, mass meetings and everything else that goes with organized labor.

Not long ago business men could say to a hospital superintendent, "You have a cinch; no union labor to deal with." I am wondering whether the time will come when pickets will try to induce an automobile accident victim to go elsewhere, because the hospital he is entering on a stretcher is unfair to union labor. Anything can happen.

Add to all this the thought that the end is not yet in sight.

There are busy, worrisome days ahead and we can only hope to meet each problem as it arises, relying upon the good will and common sense of the best men and women in the professions and the thought that the great American public will see to it that nothing destroys the finest hospital system in the world.

Anyway, I am glad to have this off my chest.

Utilizing the Public Library

The value of hospital libraries to patients has been proved, but few hospital superintendents have been able to establish such a service due to the cost involved. However, when a public library is maintained in the community its facilities should be available to hospital patients. In one city, the public library maintains a substation in the hospital and sends a librarian to the hospital three times a week to issue books to the patients. If the patient leaves between visits, the nurse on the floor is responsible for returning the book to the substation. This plan has proved workable at little expense and trouble to the public library and with the loss of only nine books in over two years. — *Lewis E. Jarrett, M.D., Hospital Division, Medical College of Virginia, Richmond, Va.*

The Premature Baby

What Chicago Does for Him

By HERMAN N. BUNDESEN, M.D.*

WHEN a premature infant is born in Chicago, whether in the home or in the hospital, this birth is immediately reported by telephone, to the board of health.

If the birth takes place at home a call is made immediately by a board of health nurse. When the baby is cared for at home the board of health nurse makes a visit every day to investigate the condition of the baby and mother. If the condition of the baby is poor, so that hospitalization is advisable, the baby is transferred in an incubator ambulance to one of the large premature stations in the city. The physician is always consulted before transfer, and in most cases transfer is made at the request of the physician. If the baby remains at home and requires a heated bed this is immediately sent to the home by the board of health.

A booklet, "Our Babies," which describes in simple language the proper care of the baby, is sent to each home by the board of health shortly after the birth is reported. In addition, in the case of premature infants, another booklet, "The Care of the Premature," is sent. This describes clearly and simply the special care necessary for the premature baby.

A Nurse Is on the Job

When a baby is cared for in the hospital, the nurse follows the mother at home, gives her instructions as to manual expression of the breast so that when the baby is brought home the mother's milk supply will be maintained. Soon after the infant returns from the hospital, the nurse calls at the home to give bathing and feeding demonstrations and to supply the mother with general instructions about the care of the infant.

The nurse maintains constant contact with the mother. In any instance in which breast milk is desired by the physician, and the family cannot afford to pay for it, this is supplied free of charge by the mothers' milk bureau of the board of

health, whether the baby is in a hospital or at home. If the people have a private physician they are urged to return to him. Otherwise they are given follow-up care in one of the special board of health stations for premature infants. Here the medical follow-up care is maintained until the baby weighs eight pounds. At this time the baby is transferred to one of the regular board of health stations.

A New Procedure Proves Valuable

In addition to the plan outlined above the board of health has recently instituted a new procedure which is rapidly proving valuable. Immediately upon notification of birth of a premature infant in a hospital or a home, a special nurse, well trained in the care of premature infants, makes a personal visit to the place where the infant is receiving care. Here, the form seen in Fig. 4 is carefully filled out. By this method the board of health has an accurate and immediate check on the actual care that every premature baby in the city is receiving from the time of birth.

Within twenty-four hours these findings are carefully examined by a board of health physician specially trained in premature infant care, and by the director of the maternal and infant welfare bureau of the board of health. Each point noted in the form that has been filled out by the nurse is given consideration. All instances in the matters of resuscitation, oxygen administration, feeding, maintenance and warmth, are noted.

When it is deemed advisable, the doctor or the hospital is immediately contacted, either by telephone or by personal visit, and these questions of care are discussed. The board of health feels that this procedure will give a much better insight into the actual care that each premature baby in Chicago receives, and also will give excellent opportunity to make suggestions and corrections at a time when they will be of value.

From February, 1935, to July, 1936, the board of health of Chicago conducted a survey of hospitals in the city to determine the facilities available for the care of the premature infants.

This survey included a visit to the nursery of

*Prepared in collaboration with William I. Fishbein, M.D., Edward J. Denenholz, M.D., and Helen Bachle, R.N., of the Chicago Board of Health.

each of the seventy-eight hospitals caring for maternity cases. The work was carried out by a nurse who had many years of experience in one of the large premature stations in the city, the Sarah Morris Hospital, so that she was well qualified to appraise critically the material. In order to ensure uniform conditions, only this one person performed this work, although often, to aid the hospital in making corrections, a subsequent investigation was conducted by a physician experienced in the care of premature infants.

The first survey, begun in February, 1935, involved a three-month period. The basis for the investigation was a form sheet, seen in Fig. 1. By the scoring system each hospital was rated on the basis of its facilities.

Pediatricians Recommend

A list of recommendations formulated by leading pediatricians and the board of health and passed by the board of health as a requirement for the care of premature infants and the newborn full-term infants, was sent to each of these hospitals to be posted in a conspicuous place in the nursery. A copy of these requirements is seen in Figs. 2 and 3. Recommendations for the care of obstetric patients were also sent.

During, and subsequent to the survey, the superintendents of the hospitals were informed of their particular deficiencies and of the hospital procedures in which they failed to comply with the board of health recommendations.

Interviews with personnel of the hospitals were, for the most part, pleasant, and the hospitals expressed their desire to cooperate. At the time of the visit the board of health nurse making the survey was given the opportunity to acquaint the nursing and medical staffs with the services offered by the board of health nurses, namely, the 24-hour incubator ambulance service, the mothers' milk bureau, the heated bed service, the follow-up home care offered by the board of health nurses, and the medical follow-up care by the board of health premature stations.

The portable Hess incubator ambulance, maintained at the Chicago Maternity Center for twenty-four-hour service, is available for the transfer of any infant in need of it, from a home to a hospital, from one hospital to another or from a hospital to a home. The ambulance, equipped with a portable oxygen tank and with facilities for injection of intramuscular blood, is accompanied on all trips by a physician and a nurse. The use of this ambulance prevents overexposure of the infant and does not make transfer a hazard.

Another service is the mothers' milk bureau, established in April, 1936, for the purpose of sup-

FORM SHEET SHOWING COMPARATIVE FACILITIES FOUND IN FIRST, SECOND AND THIRD SURVEYS

	Number of Hospitals Meeting Requirements as Designated			
	Surveys:	I	II	III
Accommodations				
Separate room for prematures.....		2	5	7
Incubators				
Grade 1 (commercial).....		51	55	55
Grade 2 (homemade).....		11	11	13
No incubators.....		16	12	11
Oxygen				
In delivery room or nursery.....		55	61	64
Portable tanks elsewhere.....			13	12
No oxygen.....			4	3
Equipment				
Individual equipment				
Bath basins.....		62	77	76
Thermometers.....		21	22	41
Soft catheters (feeding).....			78	79
Tracheal catheters.....			78	79
Running water in nursery or workroom....		64	65	68
Cans for soiled linen or diaper bags.....			77	79
Proper temperature of nursery or room....			78	79
Hygrometer.....		3	9	13
High-low thermometer.....		1	1	3
Heated bath table.....		11	10	12
Wool clothing.....			9	6
Provision for refrigeration of feedings				
Ice box in nursery.....		22	27	32
Other ice box.....		56	51	47
Separate feeding equipment for prematures.			8	11
Nursing Care				
Graduate nurse in charge of premature infants and obstetrical division				
During 24 hours.....			47	53
Less than 24 hours.....			31	26
Supervisor with special obstetrical training..			44	53
Satisfactory personnel.....			66	67
Gown technique employed.....		41	37	40
Face masks—technique employed.....			25	31
Washing of hands.....			34	58
Staff Pediatrician				
Routine charge of all prematures by pediatrician.....			16	13
Consulting pediatric service.....			36	57

Fig. 1.

plying breast milk, free of charge, for premature infants or full-term infants in need of it, and whose parents cannot afford to pay for breast milk. At present approximately 4,000 ounces of breast milk are distributed by the board of health every month. This milk is supplied both to infants in the hospital and in the home.

Heated beds are loaned, free of charge, by the board of health to homes or to hospitals for premature infants who have sufficient weight, who are nursing well enough and do not require further hospitalization. Experience has shown that these infants will progress better at home, nursing from the mother's breast, than in the hospital.

Heated beds are also loaned in instances where home conditions with regard to heat are not satisfactory. These heated beds are modeled after the Nobel pattern; being constructed of galvanized tin and heated with an electric light bulb. Twenty of these beds are now in service. The average length of use of the bed by the baby is between two and four weeks. During this time the nurse makes a daily visit to check on the temperature of the baby and the bed.

MINIMUM REQUIREMENTS FOR HOSPITAL CARE OF PREMATURE BABIES TO BE POSTED IN A CONSPICUOUS PLACE IN THE NURSERY.

ACCOMMODATIONS—It is recommended that if possible, a separate room be set aside for the care of premature infants. Otherwise they may be cared for in the nursery.

Every hospital should have some type of heated bed in the nursery or premature room.

Oxygen should be used whenever indicated and a supply for use in emergencies with necessary equipment should be kept in the room occupied by the premature infants.

Provision for the prompt transfer of the premature infant from the delivery room to the nursery should be made, so that there is no exposure of the infant to chilling.

EQUIPMENT FOR NURSING CARE—Individual equipment should be provided for the premature infant, especially a bath basin and a thermometer.

If the premature infant is cared for in the nursery with the other infants, it is advisable to keep the feeding equipment for stored breast milk (droppers, nipples, etc.) in a separate place from that of the other infants.

Every baby should have his own catheter.

There should be running water in the room or nursery, or it should be easily accessible.

Cans or diaper bags should be available for soiled linen and diapers. If possible, a warmer for clothing and diapers should be available.

The room or nursery should have a "high and low" thermometer (to show the temperature variation within 24 hours) and a hygrometer.

A heated bath table is desirable.

NURSING CARE—The nursing care of the premature infant should be supervised by a graduate nurse, who has had special training in the care of the premature infant. The Board of Health, upon request, will send a nurse to give instructions in the management of premature infants. A twenty-four hour nursing service should be provided. Nurses and attendants with respiratory or intestinal infections should be excluded from the nursery.

A minimum amount of handling is advised for premature infants. There are few nursing procedures, with

the exception of weighing and bathing, which necessitate removal of the infant from the heated bed.

Wool is the preferable material for the clothing of the premature and the infant must, at all times, be guarded against exposure to cold during dressing.

It is recommended that physicians, nurses and all others entering the room in which the premature babies are cared for should wear a clean gown and face mask should be isolated.

The room temperature should be 78-80.

Proper nursing hygiene, especially washing of hands is essential to prevent infections. Infected cases should be isolated.

It is advised that every premature baby receive breast milk. If the milk is obtained outside of the hospital, it should be boiled in the hospital for from one to two minutes before it is used.

The Board of Health, upon request, will furnish information as to where breast milk for premature infants can be obtained.

Nurses caring for premature infants should be familiar with the methods of treating cyanosis in such infants.

It is strongly recommended that the obstetrics department in hospitals where it is customary to place the responsibility for care of the new-born upon the pediatric department, notify the pediatric department in advance of every delivery in which the uterogestation is expected to be less than term and more than four months. It is also suggested that the pediatric department respond to such notification by assigning to the delivery room, an attendant, especially trained in the early care of premature infants. Such attendant should be a member of the hospital personnel and constantly on call. The premature infant should always be placed under the care of the premature department immediately after birth.

DISCHARGING INFANTS—No premature infant who will not be under the care of a private physician at home, should be discharged from a hospital without first notifying the Board of Health. If parents are not financially able to have a private physician for the infant after its discharge from the hospital, the Board of Health will assign a nurse to the home to give instructions to the mother and to render the necessary follow-up service.

Simon D. Sidelman, M.D.
President, Board of Health

Fig. 2.

Approximately six months following the first survey, a second investigation was made, the results of which are also tabulated in Fig. 1. It was gratifying to observe the commendable cooperation of many institutions—suggestions had been adopted, procedures modified and facilities improved. Several premature nurseries had been constructed, incubators obtained and new equipment provided.

A third survey, begun approximately ten months after the second, has recently been completed, and even more consistent improvements are apparent. On this third survey it was found that interest in nurseries had been awakened, hospitals had become "nursery conscious," physicians and nurses were enthusiastic and on the alert in the care of the premature and new-born infant. These improvements can best be determined by the columns of figures in Fig. 1, illustrating the comparative facilities found in the first, second, and third surveys.

In the course of the third survey, it was observed that four institutions had installed observation windows on the doors or walls of the nurseries to aid in keeping out any unnecessary individuals and curious persons, and to minimize the actual contact of the infant with relatives and friends. This is a factor in the prevention of upper respiratory infections. There are now only three hospitals in Chicago, caring for maternity cases, which do not have observation windows in the nursery.

A few institutions had a "family towel" system

in the nursery, the same towel being used by one, or a group of nurses, for several babies; other institutions were similarly lax in their towel technique, inasmuch as proper equipment was not properly used. This has been remedied so that individual toweling most often with paper towels now obtains in all hospitals. Equally astounding was the practice of depositing soiled linen or diapers on some convenient piece of furniture or on the floor. Provision has now been made for cans for soiled linen or for diaper bags in every institution. It is by careful scrutiny and supervision of such details, that possibilities for infection are lessened.

The ideal provision for refrigeration of feedings was considered to be an ice box in the nursery, since by this means the ice box is used solely for this purpose and the infant feedings are kept apart from other food, from vaccines or serums, and from other material.

There is little doubt that ill-advised and improper nursing procedures, such as overfeeding the small premature, instituting feedings too soon after birth, giving bottle feedings instead of breast milk without first making proper effort to secure breast milk, administering feedings at too frequent intervals, inexperienced and injudicious handling of the infant, and overenthusiastic attempts at

RECOMMENDATIONS FOR THE HOSPITAL CARE OF THE NEWBORN

The Newborn Department of the hospital should preferably be under the general direction and supervision of the Pediatric Department.

NURSERY The nursery should be on the same floor as the obstetrics department, and should preferably comprise rooms as follows:

1. A delivery room, complying with best standards of air conditioning, (see temperature, humidity, ventilation and lighting).

2. A service room, for bathing and caring for babies, having running water, anointer room temperature, somewhat higher than the nursery, and suitable equipment.

3. An isolation room, for infective conditions, so arranged that all preventive precautions can be carried out.

4. A room for premature infants, equipped according to the regulations of the Board of Health.

Individual bath basins should be provided if possible.

If there is no milk laboratory, where the feedings are prepared, a separate set of utensils should be kept in a kitchenette on the obstetric floor, to be used only in the preparation of milk formulae for infants. The ice box should be either in the nursery or on the same floor as the nursery.

PERSONNEL The staff pediatrician, resident obstetrician, and nurses should direct the care of the newborn. The latter two should have special training in care of newborn infants. A supervisor, preferably a graduate registered nurse, familiar with the care of newborn infants, should be in charge of the nursery. A nurse of at least junior standing should be in charge during the absence of the supervisor.

The entire personnel should be trained to recognize quickly the danger signs occurring in the newborn, viz: cyanosis, fever, excessive vomiting, bleeding, icterus, diarrhea, pustular infections, etc. When an emergency arises, a member of the medical staff must be called at once.

BREAST MILK All members of the hospital staff having to do with infants should be taught to realize the importance of breast milk to the newborn infant. Mothers should be impressed consequently with the importance of breast feeding. There should be at least one person, preferably a nurse, skilled in the technique of manual expression of breast milk. The person should train the student nurses, and every mother should be taught manual expression before she leaves the hospital.

The Board of Health will send a teacher of manual expression to the hospital or to the home upon request. This service is available either to the staff or to mothers. There are two good reasons for teaching mothers how to express the breast milk:

1. The babies are benefited—not only the baby of the mother who produces the milk but other babies whose mothers, for good reason, cannot produce enough milk, every hospital with a maternity service should try to have always on hand an excess of breast milk for the less fortunate infants.
2. While increasing the amount of the mother's milk, she is at the same time taught how to carry on for herself after she gets home and is on her own responsibility.

ROUTINE OF THE PERSONNEL

Only authorized persons should enter the nursery or prepare the feeding formulae.

All persons handling newborn infants must be Dick and Schick test negative, and should have negative nose and throat cultures, including cultures for hemolytic streptococci.

No person who is ill or has any signs of illness should under any circumstances be permitted to enter the nursery or handle a newborn infant.

Every person entering the nursery should first put on a clean gown, head covering and do not on regular duty, a face mask, and should thoroughly wash the hands, preferably in an antiseptic before entering the nursery.

The hands should always be washed after attending each infant, and after using a rubber bulb or syringe in the toilet. The baby should not be fed on the same table that is used for changing the diapers or bathing.

In handling the babies, a blanket or diaper should protect the infant from the nurse's uniform. If the baby has a nasal or eye discharge and such discharge comes in contact with the nurse's uniform, the infection can easily be transmitted to another infant. It is safer to change the baby's diaper while in the crib or bassinet if possible. If not, a clean diaper or sheet should be put on the table. For bathing, not more than two babies should be on the dressing table at any one time.

INFANT ROUTINE When an infant is taken to its mother for feeding, it should be handled only by the nurse and the mother.

No baby should be removed from the nursery for feeding during visiting hours when there are visitors in rooms and wards.

In transporting a baby between the nursery and mother's bed, he should be protected against chilling and excluded from contact with infection.

Every newborn infant should have a thorough physical examination by the staff pediatrician soon after birth and again at discharge and a record of the findings should be made.

Every morning at bathing time, some competent person should be in the nursery to inspect all babies for:

1. Skin infections, such as beginning impetigo, urticaria, hives, beginning red infection, or bleeding.
2. Mouth infections, such as thrush.
3. Eye infections.
4. Abnormal stools.

NOURISHMENT It is suggested that all standing orders for supplemental or complementary feeding should be discontinued.

Every baby should be treated as an individual case.

This is very important! If any food other than breast milk is necessary, it should be given immediately after the breast milk, but complementary feeding should be prescribed only by the obstetrician or pediatrician in attendance. No artificial feeding should be prescribed until every resource for obtaining breast milk has been exhausted.

Three or four hours after the delivery, the baby is usually fed on plain, boiled water, then every four hours, until the mother's milk is available, after that water is offered between nursings.

Twenty-four hours after delivery the baby is usually put to the mother's breast, and every four hours thereafter.

If indicated a beginning is now made in teaching the mother manual expression and particularly the importance of emptying the breasts completely at every feeding.

If this procedure is used the mother should have sufficient breast milk to take care of the baby's needs and should be skilled in manual expression by the time she leaves the hospital.

GENERAL The mother should have demonstrations and instructions in bathing, handling and general care of her baby preferably in a room not able for the purpose.

Instructions given the mother at discharge should be written rather than verbal.

If the cord is not fully healed at the time of discharge, the written instructions should include directions for the care of the cord.

Usually babies weighing less than five pounds should not be discharged from a hospital unless they nurse well, the mother has plenty of breast milk and the home conditions are satisfactory.

Babies of low vitality level should be put on the same regime as the premature baby. (See instructions on care of the premature infant.) They should not be discharged from the hospital while in this condition.

Simon D. Sidelman, M.D.
President, Board of Health

Fig. 3.

resuscitation, have often precipitated an unfavorable outcome.

Since premature infants enter the world with a decided handicap, they are deserving and in need of carefully supervised nursing care. A graduate nurse in charge of premature infants and of an obstetric division during the entire twenty-four-hour period, was found in 47 hospitals on the second and in 53 hospitals on the third survey. Satisfactory personnel was scored in 67 hospitals in the third survey. This included either hospitals which employ graduate nurses or hospitals with an accredited training school.

In the remaining institutions, nursemaids, undergraduate nurses, nurses from nonaccredited schools, were in charge of the premature work. Thirty-one hospitals in the second survey and 26 in the third survey had no twenty-hour supervision. Supervision was usually lacking at night, a time just as vital to the welfare of prematures as is the daytime.

There is little doubt that proper gown and face mask technique is an important aid in reducing the incidence of cross infection. To be effective, however, these must be properly employed. Gowns and face masks should not produce a sense of false security, and must not predispose to laxity in the essential point of washing the hands.

During the investigation it was occasionally

observed that face masks were not clean; were often taken from the nurse's pocket; were touched or handled by the nurse without afterwards washing her hands. It was also noted that gowns were sometimes carelessly and improperly put on, that occasionally soiled gowns were used. These shortcomings and errors of technique were diplomatically called to the attention of the nursing staffs in these institutions.

Correct and adequate washing of the hands cannot be overemphasized. This procedure is necessary to lessen the incidence of infection. Hands should be washed thoroughly on entrance to the nursery before caring for the infant, after changing the diaper and after handling any personal articles, such as handkerchiefs. In a large premature station in the city, washing the hands is scrupulously supervised and, in this institution, without the use of gowns or masks, infections are a rarity. Because washing of the hands was considered adequate in only 34 institutions in the second survey, efforts were made to encourage more rigorous observation of this recommendation of the board of health.

The nursery personnel and the administration of individual hospitals in which hand technique was not considered satisfactory were informed personally of this fact and were asked to expend every effort to improve their technique. On the

Date <u>10-22-36</u>	
Premature Infant Investigation	
Name of Infant <u>Baby Boy Brown</u>	Was infant put in an incubator? <u>Yes</u>
Address <u>718 Duane St. S. C.</u> Date of Birth <u>10-21-36</u>	How long after birth? <u>Immediately</u>
Place of Birth <u>St. Mary's Hospital</u>	Type of Incubator <u>How Incubator Bed</u>
Weight at Birth <u>3 lbs. 15 oz.</u> No. of Weeks Premature <u>8 wks.</u>	Can child maintain his body temperature? <u>Yes 99° to 100°</u>
Condition at Birth <u>Fair</u>	How often is the temperature of the baby taken? <u>3x daily</u>
Name of Doctor <u>Dr. M. J. Smith</u> Address <u>510 Fifth Avenue</u>	Has the infant had any intramuscular injections of whole blood, or fluids given subcutaneously? <u>Yes</u>
Type and Length of Labor <u>31 hrs. Brach. Delivery</u> Maternal Complications <u>None</u>	If so, state what was given, the amount given and the date and time it was given <u>Whole Blood 5cc given 10/21/36. Saline & glucose 5% 14cc given once 10/21/36</u>
Immediate care given infant at birth	Feeding
Was resuscitation required? <u>Yes</u>	How long after birth was the infant fed? <u>12 hrs.</u>
If so, state methods used <u>Oxygen, Tracheal Catheter</u>	How often is the child being fed now? <u>Every 4 hrs.</u>
Was there any cyanosis? <u>Yes Intermittent</u> Type <u>None</u>	Type of feeding being used <u>Breast Milk when available otherwise Sterilized Formula</u>
If so, how soon after birth <u>At birth</u>	What is the amount of feeding ordered? <u>4 cc & 3 hrs</u>
What treatment was used for the cyanosis? <u>Oxygen</u>	How much feeding does the infant take? <u>As ordered</u>
<u>Oxygen</u>	What method is used to feed the baby? <u>Gavage</u>
Length of time given <u>Constant or intermittent Continuous</u>	Does Cyanosis develop during feeding? <u>Slight cyanosis after nurse is long</u>
How long after birth was oxygen used? <u>Still giving continuously</u>	Remarks & Suggestions: <u>Will report Whole Blood Rec. 10/21/36. Saline & glucose 5% Rec. to be given twice daily until infant is in condition to take water by mouth. Breast Milk to be received 4 cc & 3 hrs tomorrow. Suggested obtaining Breast Milk from Board of Health District Milk Station, so that infant may receive entire Breast Milk feedings.</u>
Provisions for the administration of oxygen <u>How Oxygen Bed</u>	
Stimulants <u>Syringe of Stimulant 4th to 6 hrs</u>	
Birth Injuries <u>None</u>	
Congenital Malformations <u>None</u>	
Other Abnormalities <u>None</u>	
Remarks: <u>Condition seems fairly good. Color - improved</u>	

Fig. 4.

third survey, fifty-eight hospitals were scored as having adequate hand technique.

Adequate nursing care of the premature infant must necessarily include careful follow-up nursing in the home after the baby leaves the hospital. Too often, the infant is given efficient and effective care in the hospital, only to be sent home without sufficient provision having been made for the follow-up care. Intelligent nursing field service unquestionably is a potent factor in reducing infant morbidity and mortality, especially is this true of the premature infant. Hospitals should assume some of the responsibility in carrying out such a program. It is here that opportunity exists for cooperation between the hospitals and the various public health bodies. In Chicago such a plan is at present successfully being carried out.

The medical care of the premature infant is best supervised by the pediatrician, since his attention is focused entirely on the infant. The obstetric staff is encouraged to notify the pediatric staff in advance of any expected premature birth.

Just as the nursing follow-up service should be adequately arranged, so should medical after care be part and parcel of the hospital responsibility. Again, cooperation between hospitals, infant welfare societies and out-patient clinics is a necessity.

Cause of Death Often Obscure

It may be well to mention at this point that the cause of death in premature infants and newborns is often obscure. It is only, however, by an accurate knowledge of the cause of death in premature and newborn infants that physicians are able to meet the existing challenge of infant mortality. Carefully performed autopsies are a definite aid in establishing the true cause of death. If physicians and hospitals would make every effort to perform careful postmortem examinations on all infants and thus establish the true cause of death, then effective measures could be outlined that would combat these causes.

Pediatricians almost universally agree that the food best adapted to all infants, particularly premature infants, is mother's milk. Much of the board of health program has been concerned with the education and encouragement of the laity in this direction, and with fostering this principle in the minds of medical men. In larger premature nurseries the breast milk supply can be obtained from wet nurses maintained on the premises. In smaller institutions in Chicago, when the mother's milk is insufficient, milk may be secured from other mothers with an overabundant amount, from large maternity hospitals or from the mothers' milk bureau.

Many times breast milk feeding is thwarted

because of standing orders in the hospitals for supplemental and complemental feedings. In frequent instances, the advisability of instituting artificial feeding is left to the discretion of the nurse, to whom the importance of breast milk has not been stressed. For these reasons, the board of health has recommended that no standing orders for artificial feeding be made in any hospital nursery. This is done mainly so that more conscientious efforts are made to stimulate the supply of breast milk, and because the infants who receive no complemental feeding will nurse the breast much more vigorously than the baby who receives complemental feedings, thus increasing the supply of breast milk. The nursing staff should be impressed with the importance of breast milk feeding, since upon their cooperation depends largely the success of the breast milk program.

In this survey ratings of each individual hospital were made with regard to the number of newborn infants that were breast fed, partially breast fed or artificially fed when the infant left the hospital. Those with low breast milk ratings were encouraged to utilize every effort toward improving this condition. In the survey recently completed, there were only three institutions in the entire city in which more than 25 per cent of the infants were discharged on an entire artificial feeding régime. Eighty per cent of the hospitals discharged more than one-half of their infants with no feeding other than breast milk. In every Chicago institution, save three, at least 75 per cent of the infants were discharged on entire or partial breast feedings.

Providing Flower Vases

Flower vases must be provided by hospitals in considerable numbers to hold the cut flowers that are constantly being sent to patients. While the hospital encourages the sending of flowers to its patients, the cost of providing and replacing vases amounts to a considerable sum in the course of a year.

Substantial glass vases that will not tilt or break readily cost at least 50 cents each. Multiply this sum by about half the number of patients in a large institution and the result is quite an expensive item. Various types of unbreakable vases are on the market, but some of these have been found unsatisfactory as flowers wither quickly in them.

Discarded equipment, however, can frequently be salvaged and utilized for the purpose. Discarded aluminum pitchers serve the purpose admirably when they are painted and decorated in the occupational therapy department. Chipped, discarded enamel ware, such as dressing cans and forceps holders, can also be made into attractive flower vases. A little molding and a little colored paint are all that ingenuity requires for the purpose.—*Jacob Goodfriend, assistant director, Montefiore Hospital, New York City.*



The entrance, looking out



Seen from the park



Children's waiting room

From Rochester to



and looking in

WITH physical facilities equipped for the care of ear, nose and throat as well as teeth, the Eastman Dental Clinic of Stockholm, Sweden, recently opened its doors to the indigent children of that city.

Patterned after the well known clinic at Rochester, N. Y., the first to be founded by the late George Eastman, the Stockholm clinic was erected through a gift of \$1,000,000, made by Mr. Eastman to the municipal government to cover the structural costs of the plant and to finance an orthodontia department.

The plan of the clinic centers in its entrance hall, which extends the width of the building. The waiting room, with its control desk and tooth brushing room, is centered directly behind the hall. The dental treatment room is beyond, facing on the park. It has accommodations for 38 dental units.

Up the stairs are the orthodontia and surgical departments, and the ear, nose and throat unit. This last is comprised of consulting and waiting rooms; an examining room; two operating rooms; scrubbing rooms; anesthesia room, and six wards.

er to Stockholm



Where the nurses and the students lounge in the modern manner



Main stairwell



Treatment room



Fear of the dentist cannot compete with the charm of this waiting room—with its birds, fish, toys, books—for the attention of the child's mind

Many "Musts" for an Intern

By GEORGE T. KERSEY, M. D.

THERE are a number of essential points to becoming a successful intern. It is necessary to remember that we owe our utmost loyalty to the hospital giving us the opportunity to learn practical medicine. We must consider the welfare of the patient entrusted to our care first and our own personal feelings last.

It behooves us to develop good professional habits during our stay in the hospital. The habits an intern develops influence markedly his later professional life.

It is advantageous for an intern to learn as many nursing procedures as possible. A good doctor must be a good nurse. When an intern enters private practice, he will not for many years if ever be able to have a nurse to do his bidding. He will be called upon to give enemas, bathe babies and prepare hypodermics. He will have to teach relatives of his patients nursing procedures. An intern should not be ashamed or think it beneath his dignity to ask to be shown how to prepare hypodermics and to change babies' diapers.

In the Quiet of the Night

At night when on duty an intern should answer lights with the nurse if she is being rushed and if he is not busy. This is a good time for him to learn nursing procedures. Before leaving the ward he should take a flashlight and noiselessly see if everyone is asleep and comfortable. Many patients become restless late at night because of the new hospital environment, fear of impending operation or pain. Sedatives given to them earn their gratitude and enable the intern to rest without getting up to see irritable patients.

An intern should learn to make surgical supplies. Later in his private practice he will find it economical to be able to make sponges, flats, tampons in spare moments. Prepared surgical supplies bought in small quantities are expensive and most men just finishing an internship are not wealthy.

A good intern must be a good secretary. It is his duty to see that all charts and records are properly filled out before they are sent to the record room for filing. Many charts go to the record room incomplete as to final diagnosis and

operative findings. This causes great inconvenience because records cannot be filed until completed in every detail. It is the intern's duty to see that the attending men complete their records. This aids the record librarian by permitting her to file records without having to annoy nurses, interns and residents by asking about findings weeks after the patient has left the hospital. An incomplete record is a mark of inefficiency and although the intern may be guiltless he is blamed.

Studying the Chart

Immediately after an attending man finishes with a chart the intern should look at it for new orders and to note progress made. If the orders concern him, he should attempt to carry them out as soon as possible. If they are for the nurse, he is able to see that they are carried out. The intern should never fail to call the supervisor's attention to orders he writes. If the supervisor is not available the chart should be left open on her desk. Within half an hour the intern should go to the patient concerned and ask if the procedure has been carried out.

It is important to keep laboratory work up to date. The findings should be on the patient's chart within eight hours after admission. If because of some emergency the work cannot be completed on schedule, the attending physician should be so informed. Findings should be recorded immediately after completing the work so they won't be forgotten or lost.

When a patient is admitted the intern should notify the physician immediately and tell him the entrance diagnosis, pulse, temperature, respiration and blood pressure, and, if the case is surgical, he should also notify him of the blood and urinary findings.

There has been a decided tendency in the past to draw fine lines between the duties of intern, resident and nurse. There can be no definite demarcation of duty in medicine. The intern's first duty is to his patients. He must attempt in every way possible to cooperate with his superiors to make hospital and clinic routine as simple and harmonious as possible.

The intern should not cater to one physician

more than to another. Never should he question aloud a diagnosis unless asked to do so by the attending physician, or discuss a diagnosis or treatment procedure with a patient or with his friends and relatives. He should not talk about the merits or the faults of the hospital with laymen.

In the emergency room, the intern should never administer treatment that he would not want someone to give him in a similar circumstance. On wards he should never give treatment to a patient without previously consulting the attending physician and asking his permission.

In the operating room he should cooperate with and listen to the suggestions the supervisors offer. They know a great deal about operative procedures that it will take him a long time to learn independently. Before preparing an operative field he should always ask the attending surgeon how he wants the part prepared and afterwards find out if it was satisfactory.

A good intern is always on time.

He should learn to give anesthetics. He may be called upon to give them in his practice and it increases his value to the hospital he serves.

While assisting in the operative field, the intern may help the instrument nurse keep the Mayo stand straightened. Dirty instruments thrown on the stand spoil the appearance of the field and delay the surgeon. If an intern cannot anticipate the surgeon, he should ask what sutures and needles will be wanted and relay the information to the instrument nurse.

After an operation the intern should see that the postoperative orders are on the chart before the chart and the patient return to the floor. If familiar with the surgeon's postoperative routine he may telephone the ward supervisor and have her prepared in advance. It is the intern's responsibility to see that the operative findings and the name of the operation are on the chart within forty-eight hours.

To have a good appearance is half the battle. People believe that a clean doctor is a good doctor. He should wash his hands in the presence of the patient before making an examination. Finger nails should be kept clean. Nothing looks worse than dirty finger nails on a doctor's hands. His hands should be soft, and his hair trimmed; his shoes should be clean and his uniforms spotless.

Service Without Price

By M. H. MOOREHEAD

RECOGNIZING the value of trained and efficient volunteers, the Cook County School of Nursing, Chicago, some years ago organized and has under its direction and supervision an active volunteer service in Cook County Hospital. The service as now organized has been in operation about one year.

The organization comprises four groups under one director. The largest of these, and in point of service the oldest, is that of volunteers who have come, not as members of any other organization but as individuals, feeling that here was a definite need for service and a definite opportunity to serve.

This group is augmented in a variety of ways, from a variety of sources, but all of its members are actuated by one purpose. The person is exceptional who comes looking for thrills and excitements, which she imagines may be found here, and that person lasts only long enough to be disappointed. Of the others, no word can be said to overestimate the loyal, efficient work of these

women, some of whom have served for two or three years. The group is, of course, mobile, but the turnover is not large and its membership remains about the same.

The junior league group, though smaller, compensates for numbers with its quality of service. The group is increasing its members and its record is enviable. One staff worker, referring to her junior league aids, asked for "a dozen of each" for the coming year. The members of this group are well qualified for the intelligent service they give—a service of great value, marked by dependability and initiative which enable them to meet difficult situations.

The next group to become a part of the organization is the volunteer committee of Children's Hospital, and, as its name implies, it limits its activities to this field. This large and important group, organized last year, is composed of the wives of the staff doctors of Children's Hospital. Its members are vitally interested, capable of giving intelligent help, and practical problems are

being approached in a definite way and with increasingly good results.

The newest group, the Gray Ladies, trained and placed by the Chicago chapter of the American Red Cross as a part of the Hospital Volunteer Service, has recently been added, and gives promise of valuable and efficient service.

Except for the first named group, which is under the immediate supervision of the director of volunteers, each has its supervisor, who cooperates with the director in making all assignments and readjustments. Without this coordination, and with such diversified groups, a well adjusted organization would not be possible.

On the other hand, from such a diversity of sources, comes an equal diversity of interest and ability, and for this there is need. Volunteers are variously placed, where various types of service are required. Clinics, wards, social service, occupational therapy in the various departments of the hospital—general, children's and psychopathic—find need for and request volunteers.

Fitness for Job Is Considered

The supervising head of any department is always consulted before a volunteer is placed and, after the assignment is made, directs her work. Each assignment is carefully considered, as well as the fitness of the volunteer for the place. Each prospective volunteer is interviewed so that something may be learned of her experience, ability and interest. The supervisor to whom she is assigned is advised of the day and time the volunteer will report.

By this means, the work is ready and there is no interim of waiting until "I find something for you to do." Rather, the volunteer is impressed with the importance of her work and its necessity. It is made plain to her that the purpose of her work is intelligent, understanding service; a service that can and does supplement the trained professional worker; a service that relieves the professional worker from the less important matters, leaving her free for the more important ones that demand professional attention. There is no intrusive service with questioning and questionable sympathy with the patient, but consideration of the patient is made always the first concern.

Volunteers are asked to give two half days or one full day of service a week. In some instances, only one-half day a week is given. This usually occurs when the volunteer is a student or is one whose time is otherwise occupied. Often it is some specific service, where the efficiency is compensation for so little time given. On the other hand some few volunteers with more time at their

disposal give as much as three days a week. More than this is not encouraged. Punctuality and regularity are insisted upon and notification of anticipated absence is required. Outside of these matters, rules for volunteers are simple and brief. After all, they are volunteers, and the fact that they are coming, often inconvenient distances, and are giving of their time, must also have consideration.

In an institution such as Cook County Hospital, with its thousands of patients of all nationalities, the language problem must of necessity arise. So many foreign speaking patients with limited English, so many others at a loss in strange surroundings, through no common medium of speech, create situations that are perplexing. This seemed an opportunity for volunteer service, and the matter was discussed with Helen Beckley, head of the social service department, and with Warden Michael Zimmer, superintendent of the hospital.

Always cognizant of the needs of the patients, and cooperative with efforts to meet those needs constructively, Mr. Zimmer suggested that many language difficulties were bridged in various ways, through existing possibilities, but that there was a real need for an interpreter for Mexican patients. These people are finding their way to the hospital in increasing numbers. Many are newcomers to this country, none has language fluency. Acting on this suggestion, a definite and successful effort has been made to find the right person to fill the need.

Foreign Language an Asset

A volunteer speaking Spanish fluently has been placed in the social service department, where she not only gives efficient service, but is available on her days of duty, to act as interpreter wherever needed. This makes one less problem for nurses, patients and social workers, relieving anxieties of the family, and often, through the more understanding cooperation of friends and family, shortening the length of time of hospitalization.

This specific service is one evidence that the volunteer organization is growing in numbers, strength and scope. This growth has been made possible only through the unfailing cooperation of Edna S. Newman, director of the Cook County School of Nursing, and her staff in the various departments of the several hospitals. The volunteer is usually keen to sense this cooperation, is impressed with the dignity and earnestness of the service given and is able to take back to the community an intelligent estimate of the work done in Cook County Hospital. This cannot be without value.

Occupational Therapy—

Wise and Unwise

The slide rule of occupational therapy can find an answer to most cases, from the so called "deteriorated" patient to the treatment of a mild neurosis. The correctness of the answer depends upon the original premise, which should be reached through the cooperative analysis of physician and therapist

By ROBERT B. MCGRAW, M.D.
and AGNES CONRAD, M.D.

THE modern psychiatric hospital gives occupational therapy a large place in the programs of the majority of its patients. In larger communities, such treatment is available for ambulatory cases and for private patients confined to their homes.

Psychiatrists who would scrupulously individualize a drug prescription, or even an order for hydrotherapy, too often think vaguely when prescribing occupational therapy. The conspicuous ability of many pioneer occupational therapists has tempted psychiatrists to leave to their discretion the entire direction of policy, not formulating even to themselves what should be accomplished and why, much less what is contra-indicated for a given case.

In the rest cure era of the treatment of neuroses, the portion of the day not devoted to care of the body or complete lethargy was filled with pleasantly monotonous activity of a mildly esthetic sort, as far removed as possible from the conflicts of life. However, in recent years there have been many reports of help by crude physical labor among simple people after the confusion of military or other conflicts.

Back of the need for occupation in the interval between grave strain or illness and the resumption of habitual routine, the psychiatrist recognizes, in each case, some combination of classical emotional difficulties. We usually find long physical illness complicated by dependence, self-centeredness, anxiety or depression. The many individuals who

regress to childish overdependence during the helplessness of illness require encouragement to do for and by themselves, to take pride and satisfaction in reporting progress in self-reliance.

Those with strong narcissistic tendencies who withdraw from outside interests during excessive concern over the body need emphasis on the usefulness of what they are contributing to another individual or to a social group. A diabetic boy, recently recovered from a praecox episode, kept well during long weeks of hospitalization by making a victrola cabinet for the ward. For the cyclic personality, overcome by a loss of feeling of value of himself and of human endeavor, the tasks set must get results before he is aware of being urged or of making any effort. Overurging and overpraise make him recoil. Understatement will leave his own perception to make the first timid venture into satisfaction in achievement.

It Takes Courage

The most baffling neurotics encountered by the occupational therapist are those with invalid reactions which serve as a refuge from dreaded demands of life. Unless the threat can be removed, the impetus required is a powerful positive or negative transference, be it to physician, nurse or occupational aid. In picking the worker for such a case, contagious courage is the first essential, courage even to make the patient angry provided humor is retained and that mellowed by a sincere appreciation of the personality which is to be kept from going to waste.

The neurasthenic's conflict is more deeply unconscious than that of the hypochondriac. He cannot be expected so readily to take up his bed and walk. As with the depressed patient, urging against resistance is bad, but here praise is helpful and hard to overdo, often arousing that feeling

of potency, the lack of which is the problem of the neurosis.

Work given the hysteric must bring him a feeling of identification with those in charge or praise in large doses. Ingenious novelties and trinkets about which visitors will exclaim may be the first step in the transition from attention getting by infantile demands to that by real accomplishments. Then the interest is graduated from such trifles step by step to social and economic adequacy.

Whether anxiety will subside with such accustomed activity as needlework for a housewife who has done too much of it, or with the unusual thing, cannot be predicted without discussion with each patient and actual observation. A hand on the patient's arm may detect muscular tension not visible on the face. In effort syndrome without elevation of basal metabolic rate one pushes activity in spite of tachycardia, giving much reassurance and promising progressive improvement with persistence. In the anxiety of hyperthyroid patients, tachycardia as well as muscular tension and sense of fatigue has to be watched, but restlessness may often be quieted by properly selected hand work preoperatively as well as postoperatively.

To summarize: in handling neuroses we can utilize occupational therapy as an aid in overcoming the tendency to avoid responsibility, in increasing the feeling of potency, in directing into more adequate channels the desire for approval characteristic of the hysteric and in allaying the restlessness of anxiety states.

Safeguarding Psychotics

Manic patients and agitated depressions persuaded to work quietly by the tactful aid will tell you afterwards that they began to feel more normal when normally occupied. The warning cannot be too often stressed that suicidal attempts come not at the period of greatest inertia but just at the time when starting into or out of a depression, so that many a patient just beginning to take an interest in occupational therapy may also be interested in using dangerous tools with great cunning and menace to himself.

The same caution about tools is necessary when dealing with paranoid patients, but those institutions in which paranoids create a minimum of disturbance and are most contented, find congenial occupation rather promptly for each individual, with a maximum of initiative in the circumscribed, usually solitary activity, useful if feasible, pseudo-important at least. The drive of these people if furnished an outlet is less violent, but the physician should watch for increase in tension even in those long permitted to use dangerous tools.

The family of such a one, allowed to remain in the home, should be instructed to report to the physician any increase in tenseness of manner or violence of language, and in the intervals between his being seen by a doctor, to keep dangerous tools from him. A review of most cases discloses a story of two or three days of mounting tension before the outbreak which ended in tragedy. In all psychotic patients, erotic stimulation with resulting cumulative excitement, increase of anxiety, confusion, negativism or depression should be looked for by the psychiatrist himself as well as by the occupational aids while patients are actually at work. The occupation and care of epileptics are too specialized and complex to deal with here.

Schizophrenics Need Exercise

With the schizophrenic, approval and a relief of the sense of guilt are valuable as with hysterics but the difficulty is deeper. Doctor Conrad was given the problem of the violent, so-called "deteriorated" patients at St. Elizabeth's Hospital in 1927 and 1928. It was obvious that these people would be better physiologically if they got more exercise. She started with balls, large and small, and with a victrola. It was noticeable that those who sat day after day in a foetal position would watch the large, brightly colored balls when they were thrown by others, which was a step in advance for them in attention. Those in a little better contact would catch a large ball but merely throw it on the ground. Throwing it back to the doctor or aid came long before throwing it to another patient.

A middle-aged woman who wore her hair in two tight, small pigtales had for several years been cooperative with employees but antisocial otherwise. She astonished us one day by playing catch with a handball with the other patients for an hour, was pleased with her skill and chatted about it with the patients and employees. In a few months she was in charge of setting the tables for meals with other patients assisting her. This woman did her hair as she had at eight or so, took no interest in the bright balls meant for younger children, but her interest was caught by the type of ball a girl of eight would have preferred.

A roughly true but nevertheless helpful concept is that we catch the patient's interest at the emotional age level at which we find him living. Rag dolls were made for the Christmas sale. Some of our women in the disturbed ward could do nothing more skilled than fluff out cotton to stuff them, but these assured me with evident pride and pleasure that they were making dolls. One very assaultive woman whom Doctor Conrad had for-

merly approached only with two nurses, showed her the shirts she had made for boy dolls, button holes and all. She took no interest in the girl dolls but walked with the doctor to the day room table to admire the finished products.

The problem in the acute phase of schizophrenia is not so much that of catching the attention as of holding it. The aid who supervised the weaving of rugs in this same institution took great interest in suiting the complexity of pattern on the loom to the degree of confusion of the patient, and showed remarkable skill in the art of recalling each, just often enough, from fantasy to work, never to get a negative reaction. We cannot be sure whether novelty or old habits should be depended on here, as was discussed above under the anxieties. One acute schizophrenic will be confused by unaccustomed procedures, another will block when old habits call up old conflicts. Not infrequently a paranoid praecox woman will want to do carpentry or other work she considers a man's work.

On the whole, the gratification of a patient's expressed wishes to attempt any specific work is worth trying. The patient may be permitted by some to work out unconscious conflicts with symbolic objects, as child analysis uses toys, but this is truly analysis and requires all the safeguards of that technique. The major aim except in the exceptional case must, Doctor Conrad believes, be the progressive return of the individual to satisfaction and self-confidence in participation in normal living and it is the responsibility of the physician to see that the procedure is adapted to his individual problem.

Dispensary Has Its Own Problems

The problems are quite different in a dispensary. Occupational therapy bridges certain gaps which do not exist in hospital cases. Hospital cases are always available. Dispensary cases are here today and gone tomorrow. In dispensary practice it is particularly difficult to predict how the patient will need to be inveigled into the shop. We use this term inveigled advisedly. It is even more difficult when a fee is asked. Physicians whose practice is entirely in state service or in an absolutely free dispensary do not understand this, and occupational therapists who are attempting to do private practice are often exceedingly unaware of the difficulties in connection with prescribing occupational therapy at so much per hour.

Many clinic patients feel they should be paid for working and it is not possible to give several hours of talk—properly graded as to intellectual and emotional level—to the patient and to all his relatives and friends. Sometimes one has to over-

come the decided reaction that basketry and similar work is only for the feeble-minded. Some patients who are felt to be most in need of occupational therapy are hardest to interest. We have been rarely able to interest the severer compensation reactions or the so-called traumatic neurotics. In these compensation cases it would seem that occupational therapy might be utilized to prevent the development of such reactions, if used tactfully, when the individual is first hospitalized or first confined to bed. If not used early, the neurosis is soon frozen.¹

How General Hospital Can Help

It is perhaps not too much to postulate that a greater use of occupational therapy in a general hospital and in general practice would prevent the development of these traumatic and compensation reactions and the formation and aggravation of invalid reactions. This development has probably been much set back by the present economic situation, though the development of individual craftsmanship has probably been advanced. Occupational therapy is easily introduced and the occupational therapy spirit which pervades a whole institution and which is not too much regimented is to be encouraged. It is distinctly beneficial to patients who are started in occupational therapy on the ward to have that work carried on later in the out-patient department.

We should like here to mention a movement which we believe was originated in the Babies' Hospital, New York City, by Geraldine McAlpin. While it is not occupational therapy, it is allied to what is best in the spirit of occupational therapy. Here teachers trained in nursery school technique conduct individual work with bed patients. For semi-ambulatory patients there is a school-room with these trained workers in charge and with apparatus, games and toys. There is also a teacher for children of primary school age whose stay in the hospital is long enough to make a continuation of their school work advisable.

The regular school work idea is not new, especially in chronic hospitals, but the nursery school is. It is definitely felt that this agency cures, sometimes, as well as prevents a great many behavior problems related to illness and invalidism. It can be and is used to observe children who have, more or less, primary behavior problems. This in itself is sometimes valuable and prevents discontinuity of approach. We err at times in a too purely educational or psychiatric attitude.

We should emphasize here that we are talking particularly about a general hospital and out-

¹The article by Dershimer, F. W.: The Prevention of Traumatic Neurosis, *J. Indus. Hyg.* 16:40 (Jan.) 1934, has value in this regard.

patient department which has a psychiatric department and which has on the wards something more than a consultation service in psychiatry. We should like to emphasize also our belief that psychiatry has something of value to give to a general hospital and to a general out-patient department, provided it is not too jealous of its rights, too narrow in its scope or too cumbersome in its technique, and provided also that it is willing to learn as well as to teach and to treat.

Benefits Come From Shop Work

The shop for ambulatory patients serves several useful purposes. It helps in diagnosis by offering facilities for making special and trained observations, provided the therapist is trained and will report or record data accurately (not formulate, but report and record). The patient is not on his guard or dressed up for inspection as he is in the psychiatrist's office. Even the fact that he says he has no time to come may be important. If we had no shop we certainly could not ask him to come. The shop helps physicians who come to the hospital infrequently, perhaps once a week, by having the patient under some sort of care and supervision. At times it has prevented unwise, unnecessary or precipitate hospitalization of the patient for this work and observation. We may even say that it appears sometimes to prevent the development of a psychosis.

Occupational therapy is in both mental and general hospital wards an aid to nursing; this is also true in an out-patient department, but here the patient's relatives derive the relief and benefit directly. They are not tormented by the patient.

Workers for out-patient shops should be selected on a basis of versatility and personality rather than extra skill in any craft. When the patient reaches the point where he needs advanced instruction he can go elsewhere, for he will probably be well enough by that time. The occupational therapist should not be primarily a virtuoso.

A most delicate and treacherous part of the topic is prescribing the work. We think that it is rarely advisable for the physician alone to do this, and there are dangers in leaving it all to the therapist, and we know from experience that written communications back and forth are time-taking and unsatisfactory, nevertheless, there should be some sort of joint action. This offers greater difficulty in out-patient work than with a stable population but is none the less important. We cannot have patients monopolizing the facilities of the shop unless there is a good reason.

It is inevitable that in any group treatment various persons compete for the credit of the cure and for the loyalty of the patient. We hear from

nurses, from recreational aids, and from occupational therapists: "If I had more chance, I'm sure I could have accomplished so much." Sometimes this is pure rationalization. Occasionally it is valid and might well be heeded at the risk of upsetting routine a bit. The danger of presenting too simple projects to the highly intelligent, cultured and gifted patient should be borne in mind. This takes discrimination and also an acquaintance with the background and personality of the patient, and should be available in some adequate form for the therapist in records.

Occupational therapy received its first great impetus during the World War and we believe that it is receiving a modeling and shaping during this great depression that will be just as valuable.

This is an age of specialization. Occupational therapy is a specialty, and as such must bear the criticism as well as the praise due it. Some say that society, industry and medicine have all been overspecialized, and it is therefore somewhat of a paradox that the cry of "back to the patient" has been raised in the past decade, and that in opposition to the overspecialization there is this slogan "Treat the whole patient not just his disease." In other words, treat him not just as a case of typhoid fever, pneumonia or involutional melancholia but as a sick person. Occupational therapy is mightily involved here.

A Better Use of Leisure

And there is a broader movement, which while not as well developed seems nevertheless to be powerful. This involves occupational therapy even more. It is a movement to improve the use of leisure time.

Many people, though essentially willing, have not been trained in respect to their leisure time, and in a period of enforced idleness or illness they chafe, brood, and finally settle down to long, empty, aimless days and are dully satisfied.

Occupational therapy can help people to inaugurate a better use of leisure and can be introduced if given at an opportune time. Illness and convalescence offer very opportune times, and even a mental illness, neurosis, psychosis is a convenient time to introduce this principle, which we believe is so important culturally as well as healing. This will develop interest in the creative arts and crafts and in craftsmanship, perhaps also in working with others. With the development of the tremendous subdivision of labor in production manufacturing, there has been little in the work itself to interest the workman in the really creative aspects of his work. There has been left him, however, spare time to learn and do creative work.

Doing Right by the Neurotic Patient

In the average hospital scant sympathy and inadequate care are often the lot of the patient with a nervous breakdown because the nature of his illness is very seldom fully grasped

By WILLIAM C. MENNINGER, M.D.

EVERY well informed person connected with a general hospital is aware of the fact that a large proportion of the patients who come to the hospital have functional difficulties and show no evidence of organic disease. Further, a large proportion—probably the majority—of individuals with physical disease frequently present complaints concerned either with their own physical health and well-being or anxiety and concern about their family or business situation of a severity sufficient to influence their recovery process. The management of these patients is a problem to every person concerned with their treatment. Even more of a problem is presented by those individuals who come for help because of a so-called nervous breakdown.

In discussing the problem that is presented by the nervous patient entering the general hospital one can profitably review the concepts of the nervous breakdown as it is seen by the different persons who may be concerned, the patient himself, the hospital administrator, the nurse, the physician in charge of the patient and, finally, the psychiatrist. Their viewpoints are all different.

The problem of treatment of any nervous breakdown properly belongs in the domain of the psychiatrist, the psychiatric hospital and the psychiatric nurse. The psychiatrist would show poor judgment if he were to assume the responsibility for a surgical case, and it might follow that the surgeon should not undertake the care of an individual with a nervous breakdown. We must recognize, however, that certain types of neurotic illnesses must of necessity be treated in the local hospital by the local physician and nurses.

The term "nervous breakdown" as used by the layman refers to a multitude of clinical pictures. The patient himself usually views the situation with a great deal of concern, ordinarily with much more concern than he would exhibit over a phys-

ical illness. He may firmly believe that he has an organic illness; this, however, is colored by varying degrees of anxiety or fear and often by the physiologic symptoms of insomnia, palpitation or attacks of faintness. In any case the individual knows that he is sick and he desperately wants help. He goes to his local physician who may suspect the existence of organic disease and may send him to the hospital for examination. Even recognizing that he has no physical disease, hospitalization may be indicated for rest or for the regulation of the diet or for other purposes.

From the point of view of the hospital administrator the nervous patient presents at least two important problems of management. The first of these is the legal responsibility which the hospital assumes, not only for his care but for the care of every patient.

In the former instance, however, the hospital administrator wants to be assured so far as is possible that the patient isn't so nervous that he might lose control of himself, that he might commit some strange, irrational act or that he might jump out the window.

A second and even more difficult problem in the care of nervous patients is the fact that such patients are often nearly impossible to please. They are often complainers of the first rank. As a consequence, the hospital administrator, who is really a service salesman, finds these individuals his most difficult customers to satisfy.

To the Nurse—a Nuisance

From the nurse's point of view the individual with the nervous breakdown is usually regarded as a nuisance. Unless she has had psychiatric training the chances are that she believes that such an individual feigns most, if not all, of his symptoms. He demands more attention than the very seriously ill post-operative case in the next room. Even though she tries hard to make him comfortable "the bed isn't made right," "the coffee is cold," "the window is open too wide," "the drinking water is warm," until she grows weary of his complaints. She tries to evade him all she

can and reports to the other nurses what a "neuro," or "fuss-button," or "crank," he is, and in the end welcomes his departure.

The general practitioner responds with varying types and degrees of emotional reactions to the individual afflicted with a nervous breakdown, often in great contrast to his cold, scientific and unemotional attitude toward physical illness. The average physician's reaction to these problems depends chiefly on his own interest in and knowledge of psychologic illnesses.

There is one group of physicians who react to the neurotic patient by a show of irritation and annoyance. They can find nothing physical to treat and yet the patient keeps returning and returning, each time to complain of a new symptom or a new difficulty.

There is a second group of physicians who react to the neurotic patient with curiosity or incredulity. They may recognize the psychologic nature of the difficulty but resort to some sort of physical means as a chief form of treatment—drugs, hypodermic injections, endocrine treatment, ultraviolet radiation and other physical measures.

There is a third group of physicians who react to the patient with exasperation and even contempt and anger. They do not want to have anything to do with him, will not be bothered to look at his history as they pass on ward rounds, and infer that the patient is either a liar or a malinger.

Finally, there is a fourth group of physicians who react with oversolicitousness, sometimes pity and even anxiety. They often make the unfortunate mistake of telling the patient about his slightly elevated blood pressure or a trace of albumin in his urine or an extrasystole. The patient capitalizes on this information, magnifies its importance and invariably gets worse.

Can't Evaluate a Mental "Jam"

This reaction on the part of a physician may be in part explained by the inadequate training which most of us received in psychiatry in medical school. We were grounded in the material sciences of anatomy, chemistry and pathology, and throughout the rest of the course the emphasis was placed chiefly upon the diseased organ and its structural pathology, largely to the exclusion of any recognition of the psychologic pathology. The physician is trained to be an excellent diagnostician of physical disorders but he is too often lost in confusion in attempting to evaluate a mental "jam."

"Nervous breakdown" is a term used to include everything from headaches to fallen arches. Most often it is applied to those functional incapacitated

states in which the person is tired, nervous, weepy, and may have some secondary physical symptoms. But the designation of "nervous breakdown" is a misnomer, for almost never is there any disease or even disorder of the nerves. In almost every instance the sickness is more accurately a mental breakdown with associated physical symptoms—insomnia, upset stomach, tremulousness, fatigability and others, all of which are partial expressions of the personality.

An Avenue of Escape

But the term has dubious advantages. It is one of those tricks of the mind which all of us use to blame our mismanaged emotions on a malfunctioning stomach or a fallen womb. It excuses us from taking any personal responsibility for our failures in solving our psychologic problems. To the person who regards mental illness as a disgrace, it is much easier to believe that his nerves are out of kilter, than to be stigmatized as having "something wrong with his mind."

The real facts are that a nervous breakdown is always indicative of a partial mental breakdown. Those telegraph wires in our arms and legs and body called nerves, are only secondarily responding as a result of the disturbance in general headquarters.

In understanding these patients from the psychiatric point of view certain specific suggestions can be made about the management of such cases in a general hospital. It must be assumed, however, that if the illness is a severe neurosis general hospital care is both inadequate and ineffective. In some instances the treatment of the neurotic may be an emergency; for instance, the surgeon may have learned postoperatively that the patient's symptoms were neurotic and not organic. A neurosis may often accompany a severe physical illness, or a physical illness may occur in a very neurotic individual. Unless special provision is made, however, in the equipment of the hospital, the nursing service and the administration regulations, the general hospital is not equipped to give adequate treatment for a severe neurosis. On the other hand, mildly neurotic individuals can be cared for.

From the point of view of the hospital administrator there are certain points to be considered. First, the person responsible for the administration of the hospital has not only the right but the responsibility of determining insofar as possible the actual mental status of the patients in his hospital. If there is even a remote danger of accident, escape or suicide, it is the administrator's duty to refuse to take the patient. This legal responsibility applies to the charity patients as well

as to the pay patients. The doctor in charge may also be liable but this does not excuse the hospital.

Second, the hospital administrator must recognize that the patient's ability to complain and the many expressions of dissatisfaction are symptoms, symptoms of his illness, just as fever and cough and pain in the chest and rusty sputum are symptoms of pneumonia. The hospital administrator may try conscientiously to carry out his duty in attempting to meet the patient's complaints, failing to recognize that the solution of these complaints is often a medical problem which should be referred to the physician. In other words, the best method of handling the complaints should be left to the discretion of the doctor, and the patient should be told to refer these to his physician.

Psychiatrically, we recognize that many of these complaints may be irrational methods of obtaining attention. The satisfying solution of many of them for the patient may be quite ill-advised for his own best interest. The hospital administrator is always in the position, however, of attempting to evaluate the justification of the complaints. Just because the patient is nervous and has a special tendency to complain, the hospital administrator may be prone to underestimate the validity of the patient's statements.

The superintendent of nurses is nearly always involved in the management of the neurotic patient. She usually is called upon by the patient to listen to a series of complaints against the nurse, and in turn she may be the auditor for the nurse's troubles with the patient. In every case her judicious handling of the situation is important for the best therapeutic results.

It is safe to say that if the physician is antagonistic, is annoyed, is greatly concerned or is oversympathetic, he will probably mismanage the treatment of the illness. In other words, if he has an emotional response toward his patient's problems he is likely to get poor results.

Ignoring the Bull's-Eye

A second point in the physician's management is the proper evaluation of the various physical measures that he may use, namely, drugs, diet, physical therapy and even rest. The practice of a physician in giving intravenous sodium iodide because he doesn't know what else to do is neither scientific nor therapeutic. Every one of these procedures may be important and valuable and may be indicated, but to rely on them entirely because of their symptomatic effect is like shooting at the periphery of a target and ignoring the bull's-eye.

By all odds, the most important tool in the hands of the physician in the treatment of such

individuals is psychotherapy. In the recognition of psychologic factors in illness, the physician has no right to assume that the patient understands such a word as "psychotherapy." If the patient does need some psychologic help for a pylorospasm or a cardiac neurosis and the physician tells him that he needs to see a psychiatrist without giving any further information, the patient may immediately respond defensively, "There's nothing the matter with my mind." It is easy for him to talk about his physical symptoms because they are misfortunes, but he is likely to regard nervousness or any of its manifestations as a disgrace. Unless the physician takes the time to explain to him the psychosomatic makeup of every individual, with an explanation regarding his affective emotional equipment which dominates his physiologic functions he is not likely to accept psychologic help.

It Isn't "All Imaginary"

It is impossible to outline specific measures for handling such cases psychotherapeutically, but one can say briefly that any period of psychotherapy, even though it be only ten minutes, depends usually on two factors. First, on what the patient can be persuaded to tell the physician—the unburdening of his problem; second, what the physician tells the patient—giving him insight, reassurance and understanding. Both are essential and in general the physician must give understanding on the basis of intelligence, and not merely reassurance or refutation by such remarks as, "It's all imaginary."

The nursing care of the nervous patient in the general hospital is by all odds the most important factor in the successful therapeutic management. The physician may influence the picture greatly by his daily contacts, and yet the nurse may reinforce the physician's beneficial effect, or, on the other hand, may entirely undo his work, depending on her understanding and management of the situation. Further, although the physician may direct the course of events during the twenty-four hours, he sees his patient at most for only a few minutes each day. On the other hand, the patient is in the charge of the nursing service during the remainder of the twenty-four hours.

It is my contention that the nurse without psychiatric experience is at a tremendous disadvantage, if not at an entire loss, in the management of a nervous patient. Such a point of view is apparently held by the National League of Nursing Education which now strongly recommends and urges that every nurse have psychiatric experience in her general course in nursing.¹

¹Read at the meeting of the Kansas State Hospital Association, McPherson, Kans., October 31, 1936.

Someone Has Asked—

Should a Nurse Give Intravenous Injections?

This question originates in a fifty-bed hospital where there are no resident physicians. Staff physicians, because of this, have been accustomed to delegate to nurses some duties that are ordinarily assigned to physicians. Recently, because of the occurrence of an unfortunate tissue infection, the wisdom of this practice has been questioned.

Doubtless some nurses can be trained to perform efficiently and safely venipuncture, the insertion of hypodermoclysis needles and similar ward procedures. There are others, possessing less judgment and skill, to whom such steps should not be entrusted. There is, moreover, a legal aspect to this matter which should not be overlooked. A damage suit against a hospital or a physician would be much strengthened if it were based on an act of a nurse rather than on one of a graduate physician, especially if the treatment being given were of the type usually administered by a doctor.

A line of differentiation should be drawn between the work of the physician and that of the nurse.

How Can Gas and Electric Bills Be Reduced?

This question comes from a troubled superintendent who has observed his gas and electric bills gradually mount without any apparent reason. He asks how he may save money on these essential services.

Some steps, which in the hands of other executives have appeared effective, are set down here. Place under each switch a card bearing a polite request to turn off the light when not in use. Place the duty of turning off the unneeded light after 9 p.m. upon the night watchman and hold him responsible.

Study the cost of manufacturing electricity as compared with that of buying it from a local utility company. If electricity is employed for cooking, compute this expense and compare it with the cost of using oil, gas or coal. Place a card over each range asking for economy in the use of gas. Replace old and antiquated gas lights with modern ones or with electric fix-

tures. Replace old gas and electric ranges with new ones which are much better insulated and hence more economical.

If kitchens are not properly heated, provide steam coils for the purpose so that in cold weather chefs will not burn gas ranges in order to keep warm. To teach a hospital personnel that gas and electricity are expensive and that they can materially assist the hospital by economizing in their use is the first step in materially lessening the expense of these commodities. One aid in this is a chart placed in the kitchen which shows the total cost of gas and electricity used there month by month, and the cost per meal month by month. Continued pressure along these lines, however, is necessary to any material annual saving.

May Hospitals Refuse All Free Patients Not Emergencies?

In the present difficult financial situation this question is being discussed by the boards of many hospitals. Two expedients have rather commonly been adopted: some hospitals have ruthlessly closed wards and limited their free service to a drastic minimum; others have adopted a policy whereby only free patients who constitute an absolute emergency are admitted.

The wisdom of these policies can be determined somewhat by the financial condition of the individual institution and the provisions for the care of the indigent sick in the community in which the hospital is located. If an institution supported by tax funds is to be found nearby, it is certain that the same obligation to render free service does not rest on the voluntary hospital as is the case where but one community institution exists.

Any hospital worthy of its name will not refuse to give aid when an emergency arises, nevertheless, the definition of the term emergency is so uncertain that even the adoption of this policy is not always satisfactory unless flexibility in the inter-

pretation of the term is practiced. Emergencies may be medical or social. The head of a family who suffers with a chronic ailment which prevents him from exercising his earning power may represent a family emergency. An early malignancy or a developing glaucoma while not capable of causing immediate death may justly be called an emergency.

The hospital has no right to postpone the reception of such cases indefinitely. To admit only such urgent cases as an acute appendicitis, a fractured skull or a strangulated hernia would be to interpret the term "emergency" too strictly. On the other hand, it is unfair to expect the hospital routinely to admit chronic medical or surgical cases for prolonged study and treatment when its finances are at such a low ebb.

What Duties Should Be Given the Woman Intern?

Whether the intern be man or woman, the service expected from this member of the hospital's personnel should not vary. Herein lies the success or failure of the whole system. Many hospitals today are accepting women as interns that ten years ago would not have thought of doing so.

There is no good reason why a woman intern should not perform every type of work assigned to a man. Ambulance service, the dressing and catheterization of male patients and the treatment of all patients who seek relief in the hospital fall within the scope of her work. When a woman applies for and receives an appointment as a hospital intern and conducts herself as though she expected to be favored, courted and entertained, she jeopardizes future opportunities for all of her professional sisters.

Prudery has no place in the life of the hospital. A woman who, through claims of modesty or physical inability, expects to avoid the performance of any medical duty does not merit either her place as an intern or the high respect which her profession should command. The intern who is a coquette is capable of seriously damaging the morale of a professional staff by her frivolity and selfishness. It is this type who prevents a more widespread adoption of women as interns.

If you have any questions to ask, the Editors will be glad to discuss them in a forthcoming issue

Keep the Life Stream Pure

By JOSEPH C. DOANE, M.D.

*A study in cause and effect
for the busy superintendent*

IT WAS remarked in a recent article in this department that diseases of the blood affect every organ and tissue in the body, that a decrease in the oxygen and carbon dioxide carrying function deprives every cell of its needed energizing nourishment. Of course, a disease of the pump in this circulatory system, the heart, and of the vessels leading thereto and therefrom will exert the same effect.

In any prolonged ailment when weakened bodily structures find themselves unable to manufacture sufficient healthy blood cells a vicious circle is set up in which an impoverishment of blood produces an ever increasing inability to remedy this defect. In such diseases as typhoid fever, tuberculosis, cancer and chronic infections, the blood becomes poor in cells. This condition has been called a secondary anemia because it follows some primary condition.

No Satisfactory Excuse

One of the most tragic events that can occur in the hospital is for a patient to lose his life from a hemorrhage following an operation. The surgeon is most careful to staunch the flow of blood completely before hiding the source of a possible hemorrhage. Postoperative hemorrhages from tonsillar beds, from the vessels within the abdominal cavity and even from vessels in the stump following amputation do occur and do at times destroy life. The hospital technique necessary to the careful postoperative supervision in the case of tonsillectomies should be the most perfect. No satisfactory excuse can be given to explain the loss of a patient in this manner.

Of course, when hemorrhage occurs a sudden and acute anemia takes place. Prompt action on the part of nurses and resident physicians is life-saving. Too great emphasis cannot therefore be laid on training them to recognize the symptom picture promptly.

Hospitals should, of course, provide emergency equipment for the handling of such cases. Work-

able tourniquets, proper equipment for the inspection of tonsillar fossae, a good ward bedside light for the emergency treatment of hemorrhage of all sorts in the surgical department, and above all a knowledge on the part of everyone as to the possibility of postoperative surgical hemorrhage are often life-saving in their effect.

Often the appearance of a patient suffering with anemia reveals at once the nature of his illness and yet this term is often employed as a blanket to cover symptoms which may be caused by conditions far removed from those affecting the blood. The lay belief that blood becomes diluted and thin as if water were added has led to much quackery in medicine.

The number of red blood cells may be decreased from four or five million to less than one million or they may be increased from four or five million to seven or eight million. In the average hospital the estimation of the number of cells in the blood has become so common a practice that few stop to wonder when this technique was perfected and even how cells which are but 1/3200th of an inch in diameter may be counted when their number runs into the millions per cubic millimeter.

Once Upon a Time—

The story of this hospital procedure begins with a man in Delft, Holland, who found time from his city hall janitorial work to pursue a hobby. Anthony van Leeuwenhoek ground lenses as a pastime and it was he who first revealed to those who dropped into his shop for idle gossip the new microscopic world which he had discovered. Later Van Leeuwenhoek's lenses made possible not only the counting and measuring of blood cells but also the discovery of the cause of many diseases which had baffled physicians.

If normal human blood is drawn in small tubes and whirled in a centrifuge its cells will pack down in about a ratio of forty-six parts to fifty-four parts of liquid. After a severe hemorrhage or in cases of severe anemia but ten parts may be

solid and ninety parts liquid. In the study of blood the hospital chart often contains a page for the recording of the sedimentation curve. The sedimentation rate really signifies the speed with which the solid parts of the blood settle when it is allowed to stand in a narrow calibrated tube. The superintendent may wonder about the purpose of these sedimentation charts and tubes which he is asked to purchase.

If infection is active, cells settle more rapidly than when the patient is not diseased. Coagulation time normally ranges from four to six minutes and simply denotes the time necessary for blood to coagulate in tiny capillary tubes when it is drawn from the body. Every good hospital requires that coagulation and bleeding time be determined before a tonsillectomy is performed.

On inspecting the patient's chart a long list of figures will be observed following such abbreviations as hg., r.b.c., w.b.c. and a number of other terms referring to the types and percentages of the various varieties of white blood cells. These cryptic abbreviations of course refer to hemoglobin, the iron carrying element in the red blood corpuscle, to red blood cells, white blood cells and to the many varieties of the latter.

What History Records

Let us look for a moment at some interesting historical facts relating to this technique of counting blood cells. An investigator, Swaumer by name, in 1658 first saw red blood cells in the vessels of a frog. Van Leeuwenhoek, already mentioned, in 1674 described the red blood cell, stating that it gave to this fluid its color and endeavored to compare it in size with a grain of sand, the first recorded effort to measure these tiny bodies.

White cells were first described by Hewson in 1771 who also mentioned sedimentation and coagulation of blood. Blood platelets which play a part in coagulation were described by Donné in 1843 and forty years later Hayem connected these bodies with the coagulation of the blood. Not until 1872 was a practical method of counting blood cells described by Malassiz who devised a crude diluting pipette and counting chamber.

Thoma-Zeiss, whose counting chamber even today is used in many modern hospitals, improved the apparatus and technique of Malassiz. Hayem shortly after 1871 devised a method of expressing hemoglobin by percentage. It is interesting to note that Erlich, whose name was later to be connected with so many epochal advances in medicine, while still a student in 1877 worked with dyes in staining white blood cells and in 1898 classified these cells so completely that little addition has been made to his contribution to this day.

Erlich has been called the father of hematology, or the science of the study of the blood.

It is a common sight about hospital corridors to observe interns and technicians with a basket of slides and pipettes making their rounds. They are responding to requests for the making of red cell blood counts and of estimating an increase or decrease in the number of white cells.

The surgeon asks first of all, when confronted by the possibility of an inflammation of the appendix, as to the blood count and as to the percentage of white cells which when present in excess indicate the development of pus. If technicians and interns are carelessly trained in this technique, the surgeon is likely to be misled, needless operations performed or needful ones overlooked.

Counting Blood Cells

In the counting of blood cells, some method of dilution was of course early found necessary. Accurately calibrated pipettes which will dilute blood cells so that they may be counted by use of the microscope are therefore essential. If this part of the calculation of blood cell numbers is not meticulously performed, results are likely to be highly erroneous.

This procedure consists first of the cleansing of the finger, the making of a small wound deep enough to produce the free flow of blood, the careful withdrawal of a tiny portion of the blood without squeezing the finger, its dilution in the case of the red cell by some solution to prevent coagulation and in the case of the white cell by a solution which dissolves all but this cell which is called a leucocyte.

If one were to follow these workers to the laboratory he would observe the placing of a drop of diluted blood upon an accurately ruled counting chamber with a known cubical content and the actual careful counting of cells overlying these ruled spaces. The white cells are counted and to determine differentially the numbers of each type, a stained slide is employed. By a known arithmetical formula the worker now computes both the count of the red and white cells per cubic millimeter and the differential count of the latter.

As far as the presence of acute infectious disease is concerned, the physician learns more from a knowledge of the number of white cells and the percentage of each variety than he does from the percentage of hemoglobin or the number of red cells. If, for example, a patient with a pain in the right side of the abdomen and rigidity and tenderness of its wall is reported as having fifteen thousand or eighteen thousand white cells per cubic millimeter, the surgeon is inclined in the

presence of other findings to be swayed toward deciding that an operation should be performed immediately.

The size, shape, number and regularity of outline of the red cell point toward the presence or absence of a severe anemia. The estimation of the iron content of the red cell is largely a color matching procedure. The hospital is often asked to purchase a Talquist, Dare, Sahli or one of the many other hemoglobin estimating apparatuses now in use. The color of blood properly collected is compared in all of these instruments with a known standard and the percentage read in this manner.

Practiced in the Stone Age

The craze of bloodletting since the stone age when it was first practiced, no doubt has caused the loss of many thousands of lives. This practice probably had its origin in the old belief of Hippocrates that all disease was due to an abnormal condition of one or more of the four bodily fluids—blood, phlegm and black and yellow bile. Persons were said to be sanguine, phlegmatic, melancholic or choleric, dependent on which of these humors or fluids was diseased. Hence it was concluded that the withdrawal of blood would be beneficial. Even Thomas Sydenham, the dean of physicians of the seventeenth century, was in-

clined to place the greatest confidence in the removal of blood.

Of historic and medical interest is the fact that one Thomas Dover, a medical student who resided in Sydenham's house, contracting smallpox, was deprived of twenty-two ounces of his blood, given an emetic and exposed to cold atmosphere as a treatment for this disease. Victor Robinson, in his recent interesting book remarks that no wonder Thomas Dover decided that being a pirate on the high seas was less risky than undergoing the treatment which his physician gave him. Dover's name stands out in history as being responsible for the removal of Robinson Crusoe from his lonely island and also upon his return to civilization for giving to medicine a powder of opium and ipecac known today to the world as Dover's powder.

Benjamin Rush cured, so he thought, yellow fever by purging and bleeding and it is thought by some that George Washington might have been given longer years of usefulness had his physicians been less audacious in withdrawing blood from his veins.

Nothing has been said in this sketch as to the specific types of anemias which are attracting the attention of physicians and indeed which until now have baffled their attempts at cure. This subject may serve as a profitable and interesting topic for description in some future issue.

For Better Toast and Coffee

The superintendent of an Eastern hospital in checking the food waste of the private department of his hospital recently discovered that a large amount of toast was reaching the garbage pail. In endeavoring to discover the reason therefor he learned that private patients disliked the toast served because it was cold, hard and decidedly unappetizing. Breakfast toast in this institution is made in the central diet kitchen, approximately one-half hour before it is served. It is placed in wax envelopes and evidently was reaching the patients in an unappetizing condition.

The superintendent decided that there was little wonder that waste occurred and that patients were continually dissatisfied with their breakfast.

The following means of remedying this difficulty was devised. A new and modern toaster was procured. Covered toast dishes were furnished and these kept in the dish warmer until they were needed. The toast was made only when the trays were ready to be sent to the floor, it being then placed in a hot covered dish, protected by a napkin. It reached the patient in an appetizing condition and was routinely consumed.

The other ingredient which forms the backbone of the patient's breakfast is good coffee. Most administrators agree that the only sure way to serve good coffee to the private floor is to secure first a high grade article, next either to transport it in vacuum containers to the private

room or else, and, this is a better way, make it in small pots on each floor and serve it while it is still fresh and hot. The latter method of preparing and serving coffee probably requires an extra floor maid, but the appreciation on the part of a private patient usually more than recompenses the hospital for the expense involved. Good toast and coffee at breakfast usually more than overbalance any other defects of omission or commission.

Taking Good Advice

Andrew Carnegie was wont to attribute his success to his policy of surrounding himself with men who knew more than he did about various subjects, and being guided by their advice. The highly varied technical nature of many hospital functions indicates the wisdom of a similar policy. An executive who can select the right sort of persons to head the various departments of his hospital can well afford to avail himself of their suggestions and advice in their respective fields, and will himself benefit by using this advice whenever possible, and seeing that full credit is given to the source. Smooth running in the organization at large depends on the elimination of friction in the various parts. There is no known lubricant for an administrative machine like the mutual good will and confidence which can be generated only in this way.—F. Stanley Howe, *Orange Memorial Hospital, Orange, N. J.*

Better Than an Employees' Union

By ABRAHAM ROSENBERG

THE time has come when thoughtful hospital administrators must prepare to face certain facts regarding changing trends in hospital-employee relationships.

During the past few years there has been no opportunity for increases of salaries of workers except through a transfer from a lower paying position to one paying a higher salary when a vacancy occurred. Now that the country is apparently coming out of the depression and in the face of the attendant rise in commodity prices, hospitals must expect to include in their budgetary calculations the provision for return of salary cuts, standardization of positions, minimum and maximum salary schedules and the practice of normal periodic increases in salaries which had previously prevailed.

We Face a New Issue

More important, hospitals should recognize the growing tendency of employees to organize themselves in unions, groups or councils—a heretofore unheard of practice in hospital employee groups. In New York City we are witnessing the formation of such employee groups in many large hospitals. With the thought that it might be of interest to other institutions, I cite the experience of our hospital during the past three years.

The Hospital for Joint Diseases, New York City, employs about 400 persons in the seventeen departments of the main hospital, out-patient department, social service department and country home. In March, 1933, a group of our employees determined to organize a local council representing the professional, clerical and maintenance groups. The hospital did not object. Today, after functioning for almost four years, the council's membership is about 225. From time to time committees of the council meet with the director or assistant director to discuss problems affecting employees.

From its inception, there has existed a most cordial, sympathetic and intelligent understanding between the hospital and its employees—a reflection of the progressive and liberal attitude of the board of trustees of the hospital.

What has made it easy for this harmonious condition to exist is the definite policy of the hospital on fundamental points: two weeks' vacation with

pay for all workers of a year or more (four weeks for department heads); two weeks' sick leave with pay allowed annually to workers of a year or more; free hospitalization for the duration of a worker's illness; definite schedules and hours of work for all departments; group life insurance in which the hospital shares the expense with the employees.

The council understands its functions and has not interfered with the administration of the hospital, but rather has confined itself to constructive measures. The meetings with its committees have been mostly to discuss such matters as adjustments of interdepartmental working schedules, improvement of certain working conditions, alleged discriminations of workers, proportionate allowances for sick leave for those not employed a full year, semimonthly payments of salaries rather than monthly payments, extra vacation leaves for employees of five years' service or longer and problems of like nature.

Whenever a request has been made for a change of practice or procedure, the council has helped work out the problem so that there would be little or no additional cost to the hospital. Now that the business horizon appears brighter, a request has been made by the council for the restoration of salary cuts and a periodic increase in wages based on length of service.

Creating Good Will

Not all requests have been granted, for financial or other good reasons. The hospital, however, and this is important, fully and frankly explained these reasons at the time. I believe that this is one of the fundamentals for creating and cementing good will among all concerned.

After almost four years' experience with an employee group council there has evolved a most cordial and intelligent understanding between the hospital and its employees, and as a result of meetings held with its committees, many constructive changes in employee rules and regulations have been made. This is reflected all through the hospital and commented on by patients, doctors and visitors.

HERE IS THE SAFETY TEST

DO THE DEXTROSE SOLUTIONS
YOU ARE NOW USING MEASURE
UP TO THESE STANDARDS?



THE USE of the best raw materials obtainable—laboratory glass, pure rubber, chemicals “CP for injection”, etc.—may be taken for granted as factors found in common in the solutions of reputable manufacturers. The *uncommon* safety factors, found in dextrose solutions in *Saftiflasks*, are those which result from their biological laboratory background. For example:

- 1 The glass, even though produced to rigid specifications, is specially tested by Cutter chemists for solubility and free alkalis.
- 2 The rubber, already of highest purity, is specially treated to insure its inertness in contact with the solution.
- 3 The chemicals, already “CP for injection”, are assayed by Cutter chemists to assure that they are actually true to label.
- 4 To make certain that the fractionally distilled water is pyro-

gen free, it is tested against the presence of organic or inorganic substances. (Also see Safety Factor Number 10.)

- 5 After mixing and filling, the solutions are again chemically assayed and tested polaroscopically.
- 6 A separate department, entirely divorced from the production group, rigidly tests a representative batch of *Saftiflasks* from each lot.
- 7 Full-time technicians—specialists in the production of delicate culture material—prepare the media used for tests in bacterial and mold contamination.
- 8 Mold tests are carried on at

both room and incubator temperature.

- 9 Bacterial tests are placed in an incubator whose temperature never varies, and whose thermometer recordings are subject to U. S. Government examination.
- 10 A final test, against the possibility of pyrogenic reaction, is made by intravenous injection in rabbits. This is done by laboratory technicians especially trained in the handling of small animals.

At Cutter Laboratories, in spite of the fact that experience and equipment are *ideally* fitted for production under “100% sterility technique”—no safety factor is taken for granted. Each is examined by rigid tests—because, as the biological industry knows, *no product for intravenous injection is safe until proven safe.*

PRODUCED IN A GOVERNMENT-LICENSED BIOLOGICAL LABORATORY

SAFTIFLASKS



CUTTER LABORATORIES

BERKELEY, CALIFORNIA

111 NO. CANAL STREET, CHICAGO, ILLINOIS

PLANT OPERATION

Conducted by John R. Mannix and R. C. Buerki, M.D.

Hospital Contracts to Pasteurize

By Robert E. Neff

TOO few hospitals, perhaps, have a definite knowledge of the quality of their milk supply. Milk being one of the most important foods, the source of its supply and the mechanics of its handling and serving should command particular care on the part of all those concerned in the hospital organization.

Too many times the hospital accepts milk from the local dealer or distributor on the assumption that the supply is of proper quality. The amount of milk that would be disqualified or considered inferior if regular tests were run would be surprising.

Many public health authorities take the position that there is not and cannot be any such thing as a constantly safe milk supply. A method of determining the quality of milk by bacteriologic tests and butterfat count offers a safeguard against inferior milk. Inasmuch as bacterial counts indicate viable organisms, it is logical to judge pasteurized milk by its maximum bacterial count.

Bacterial counts are ordinarily used not as a means of grading, but as a check on the influence of animal disease and environmental factors in milk production. Milk distributors, as

a rule, are eager to work with those customers who are interested in high quality, and we venture the opinion that many vendors to hospitals are not aware of the real quality of their production, particularly in smaller communities. It is a comparatively simple matter for hospitals, by the use of their laboratories, to arrange for periodic tests of their milk supply.

Not many hospitals, perhaps, are situated so as to be able to pasteurize their own milk. This procedure, however, is not as difficult as it may appear, particularly for institutions where consumption of milk reaches a large volume. About three years ago, the institution which I represent began the pasteurization of milk. This had been considered for some time, with two aims primarily in mind: first, a quality product, with emphasis upon milk for babies; second, lower cost. The large consumption appeared to justify the venture.

At the outset, two important factors had to be considered—the source of supply and the ability of the institution to produce satisfactory quality at reasonable cost. In selecting the producers, the type of herd had to be

Beginning Next Month!

In the February issue will appear the first of a series of five articles on sterilization, from the University Hospitals of Cleveland, by E. E. Ecker, M.D., and associates. The subjects to be covered are (1) temperatures and time necessary for steam sterilization; (2) sterilization of surgical instruments and utensils; (3) disinfection of clinical thermometers; (4) concentrations of various mercurials needed for sterilization, and (5) disinfection of hand brushes by means of potassium mercuric iodide.

considered, whether Holstein, Guernsey, Ayrshire, Jersey. For rich milk with its high butterfat content, Jersey would be desirable; next in butterfat content would rank Guernsey, Ayrshire and Holstein. The condition of the herd, the barns, barn lots, manure disposal, milk houses and other facilities must attain certain standards.

Regular inspection of the producer's methods, as well as of the herd and physical plant, had to be arranged and this by a trained man, one qualified to detect unhealthy cows and otherwise know and sense the scientific factors that might be unfavorable for a good milk supply at its source. Fortunately, we were able to obtain the cooperation of the University of Iowa Department of Health, and an inspector was delegated for this service.

The accessibility of the dairy farm was an important factor; bad roads and unfavorable weather conditions could not be allowed to interfere with daily deliveries of milk to the hospital. Located as we are in the midst of a fine dairy section, no difficulties were encountered in arranging contracts with dairymen whose herds and physical plants showed possibilities of measuring up to required standards. Physical plants not accepted at first were within reasonable time brought up to standard under the direction of the inspector, and not only the hospital but the dairymen soon became proud of their plants, herds and the fact that they were vendors of the University Hospital's milk supply.

Three producers are now providing



A view of the sterilizing room.

A New MAGIC CHEF FRY TOP

TO MEET PRESENT
DAY REQUIREMENTS
OF PERFORMANCE
AND ECONOMY...

● Now gas Fry Tops with even heat distribution all over the top plates are ready for the Food Service Industry. These Fry Tops are available with top heat controls which by simply setting a dial will control desired temperatures.

The unit illustrated has two separate fry top sections. Each of these can be operated independently with a different temperature for each section. Or the two can be operated as one large area for frying. In either case the heat is evenly distributed over the whole fry section and is held accurately to the temperature desired. This eliminates guesswork, watching or shifting around to get the right heat. No more fry top zones which are too hot or not hot enough—no more meats partly overdone and partly underdone.

Magic Chef metal alloy fry top plates with raised coved edges store up heat. The entire top may be loaded and reloaded with cold steaks without effecting an excessive temperature drop.

This new Fry Top provides extra large capacity because the entire top surface from side to side and from grease trough to back is usable for broiling or frying with uniform heat.

Other features include automatic lighting, even heat high speed burners, burner radiants to store and radiate heat to fry top, Lorain Oven Heat Control, heavy oven insulation, porcelain enamel oven linings, long life oven-door counter balance springs, sanitary oven bottom.

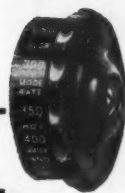
Investigate this Fry Top unit for efficiency and economy. Write for details.



Magic Chef
AMERICAN STOVE COMPANY

Where gas main service is not available, Pyrofax tank gas service may be obtained anywhere east of the Rockies.

LOOK FOR THE RED WHEEL
WHEN YOU BUY A MAGIC CHEF



AMERICAN STOVE COMPANY

BOSTON • NEW YORK • ATLANTA • CLEVELAND • CHICAGO
ST. LOUIS • PHILADELPHIA • SAN FRANCISCO • LOS ANGELES

**MAGIC CHEF
HEAVY DUTY**

*Automatic
Equipment*

FOR MODERN
GAS COOKING

about 250 gallons of milk a day, which lacks approximately 100 gallons of meeting our daily needs. We are obliged to accept the entire output of the three producers, and owing to the seasonal fluctuation of their production, it is advisable, in order to avoid a surplus, to buy a quantity of milk from a local distributor, which quantity varies according to the fluctuation in the quantity received from the producers. We plan, however, to take on a fourth producer shortly, to provide an additional quantity of approximately 75 gallons a day.

The following major points are incorporated in the contract with the producers:

1. Time of daily deliveries.
2. A minimum and maximum quantity per day.
3. An agreement to sell milk products to no other person or persons.
4. The vendor to furnish milk cans

and receptacles for the delivery of milk, these containers to conform to all requirements as to type and proper sterilization of such containers and receptacles as requested by the university department of health.

5. The University Hospital agrees to weigh each delivery and determine the butterfat content and to furnish the vendor with a receipt as to the weight and butterfat content.

6. The hospital agrees to pay the vendor on the pound basis according to the butterfat content of 3.5 per cent standard. The price per hundredweight to be governed by the current basic price as designated by the Johnson County Dairy Marketing Association, plus \$0.25 per hundredweight, with a differential in price of \$0.04 per .1 per cent in variation in butterfat content above or below the 3.5 per cent standard.

The vendor agrees to conform to the requirements of the university department

of health, with respect to the following points:

1. The dairy must be maintained at all times in such condition that as to equipment, mode of operation and quality of product it will be entitled indisputably to be classified as a Grade A dairy according to the Standard Milk Ordinance of the United States Public Health Service.

2. The herd must be examined at least once a year by an accredited veterinarian and a copy of his report must be filed with the university department of health. This examination must include blood test for contagious abortion.

3. The veterinarian's report on any new cows added to the herd must be filed with the department.

4. A list of the test numbers, with dates and results of tests on all cows in the herd, or subsequently added to it, must be placed on file with the department.

5. All members of the dairyman's household and all employees must undergo health examinations annually or at such other times as the department may deem advisable.

6. Everyone included in Paragraph 5 must have been successfully once vaccinated against smallpox, and re-vaccinated every succeeding five years.

7. Each child included in the above must be immunized against diphtheria.

8. None in the above list shall ever have had typhoid fever, and no one may be employed in the future who has had typhoid fever at any time.

9. The dairyman shall report promptly to the department all cases of current illness in his family or employees and shall carry out such restrictions as the university department of health may require.

10. The authorized representatives of the department of health shall have right of entry at any time for purposes of inspection.

11. The dairyman shall bear the expenses involved in all of the above mentioned requirements.

12. It is advised further that all individuals included under Paragraph 5 be immunized against typhoid fever every two years.

A basic price of \$2.05 per hundredweight is now paid the producer, plus \$0.25 premium for 3.5 per cent milk. The premium of \$0.25 per hundredweight is granted for the reason that the producer, in order to conform to the regulations, is naturally involved in considerable expense, not only in bringing his plant up to the required standard, but in maintaining the required technique in its daily operation. The producer not only receives a reasonably good price at all times, but has the advantage of a stable market and a freedom from surplusage.

The equipment in the pasteurizing plant consists of one 150-gallon pasteurizer, cooler, filter, bottler and cap-

UNIVERSITY HOSPITALS, STATE UNIVERSITY OF IOWA PASTEURIZING PLANT REPORT Year 1935-36

Milk received from producers:

	Gallons	Cost per Gallon	Total Cost
No. 1 Producer Orr.....	30,806.7	\$0.198	\$ 6,102.41
No. 2 Producer Bowers.....	24,508.1	0.1794	4,397.00
No. 3 Producer Keyser.....	25,685.6	0.2089	5,367.64
	81,000.4		\$15,867.05

Average cost per gallon from producers: \$0.1958.

Total daily average receipts from all producers: 221.9 gallons.

Dispensed to various hospital departments as follows:

In bulk raw.....	4,380.5 gal.
In bulk pasteurized.....	22,246.75 gal.
In quart bottles pasteurized.....	749.75 gal.
In half-pint bottles pasteurized.....	52,919.15 gal.
Total dispensed.....	80,296.15 gal.
Lost in pasteurization.....	704.25 gal.
	81,000.4 gal.

COMPARATIVE COSTS AND SAVINGS

Local wholesale costs:

26,627.25 gal. @ \$0.28.....	\$ 7,455.63
749.75 gal. in quart bottles @ \$0.32 per gal.....	239.92
52,919.15 gal. in half-pints @ \$0.40 per gal.....	21,167.66

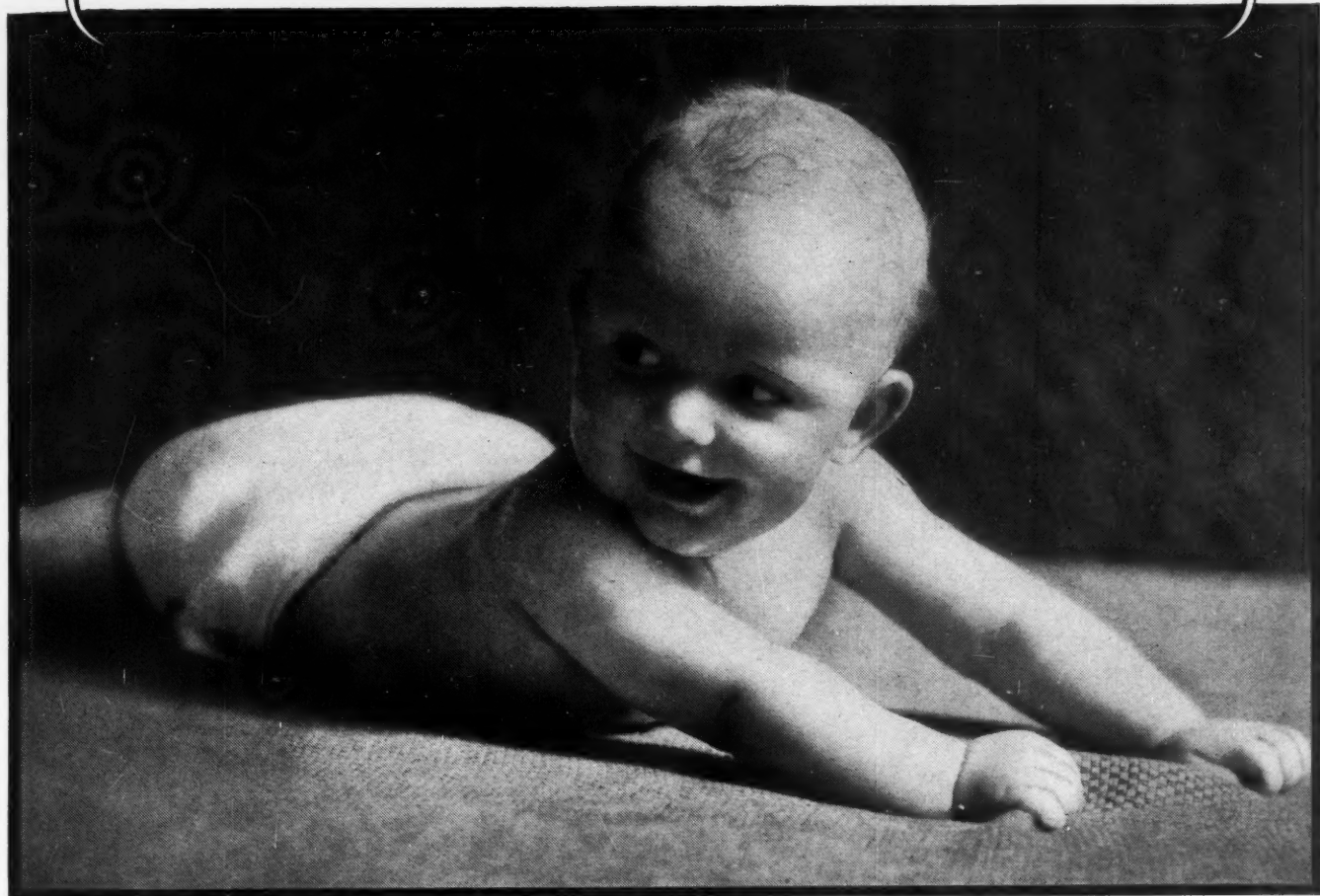
Total gallons 80,296.15. Total cost..... \$28,863.21

Our cost:

Raw milk (as above).....	\$15,867.05
Salaries and meals of employees.....	2,455.75
Bottles 54¼ gross @ \$4.60 per gross.....	251.85
Bottle caps 850,000 @ \$0.47 per thousand.....	399.50
Cleaning supplies (estimated).....	300.00
Repairs (estimated).....	200.00
Steam, water, electricity, etc.....	600.00
Depreciation on equipment and containers.....	750.00
Total.....	\$20,824.06
Savings for year.....	8,039.06
Average local wholesale cost per gallon.....	\$0.3594
Our average cost per gallon distributed.....	.2593

Savings per gallon.....	\$0.1001
Average cost per gallon for pasteurization and distribution.....	\$0.0635
Average cost per gallon from producers.....	.1958
Our total average cost per gallon.....	.2593

{ "Oh, he's only a BABY!" }



AND SOAP IS ONLY A "LITTLE THING," TOO

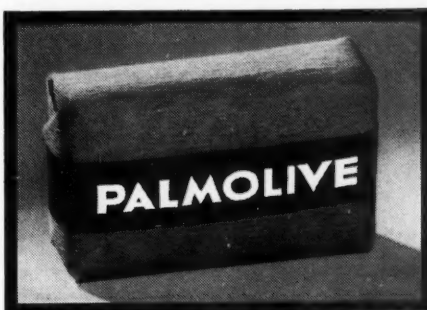
If you don't agree both are "Little Things" of real importance, consider this:

TRUE, soap is a "Little Thing," physically speaking. But . . . the *right* soap can actually help recovery . . . by being soothing to super-sensitive skins . . . by cleansing gently . . . with rich, creamy lather whether used with warm or cold water.

That's *one* reason so many leading hospitals use Palmolive—the soap that's made *only from Olive and Palm oils*. That's why many doctors tell new mothers: "Now that your baby is ready for soap and water

baths, I suggest you use Palmolive."

"Even the name Palmolive is important," a doctor told us just a few days ago. "It's such a familiar name . . . a touch of home." And no wonder! For more people buy this pure, *vegetable oil* soap—Palmolive—than



any other brand of toilet soap.

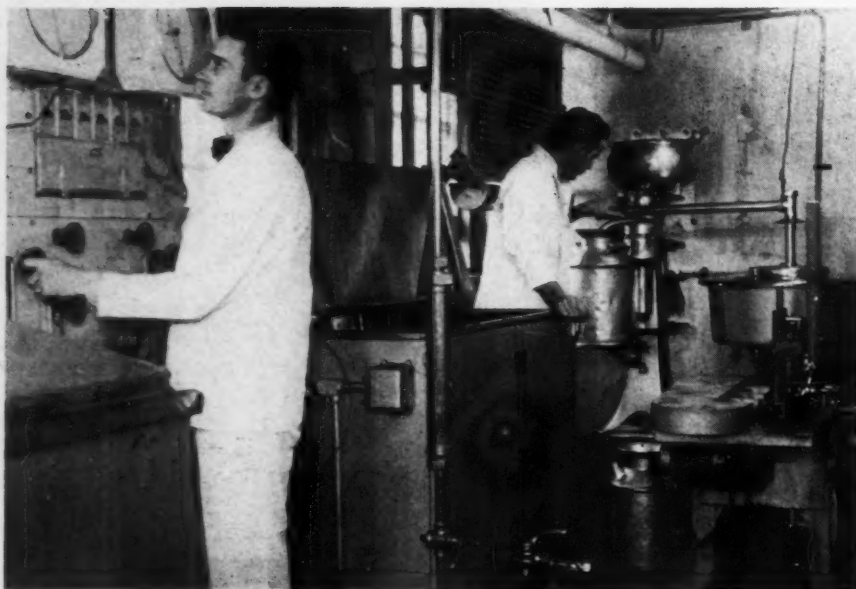
Palmolive's Extra Quality is FREE!

Yes, actually FREE! For Palmolive Soap, made with olive oil, costs no more than less-favored brands.

Your C.P.P. Representative will gladly quote on Palmolive Soap—and on the finest, most economical soaps for laundry and maintenance use, too. Or, write Colgate-Palmolive-Peet Co., Jersey City, N. J. for the valuable Free Booklet: "Hospital Housekeeping and Cleanliness." It's a dependable soap-buying guide. No obligation, of course. Send for your copy—TODAY!

Palmolive Soap

ONE OF THE "LITTLE THINGS" PATIENTS CALL IMPORTANT



per, sterilizing washer, crates, cans and racks involving an original outlay of approximately \$3,000. The chief operator in the plant is a graduate in dairying of one of the best schools of agriculture and to assist him there are one full-time man and one half-time assistant. Needless to say, the technique in the plant is carefully guarded, including all features in the handling of milk from the time of its delivery from the producer to the completion of the bottling process. Careful attention is given to sanitation, sterilization of containers, the health of employees.

At the present time the plant is bottling approximately 2,500 half-pint bottles per day, which means that all patients, as well as some of the cafeterias in the hospital, are provided with milk which "no hand has touched." The milk is served on the patient's tray in the original bottle, with a tumbler for private patients, and a drinking straw for ward patients. The cost of milk in half-pint bottles in such quantity would be almost prohibitive, and the fact that we serve milk in the original container is another distinct advantage in pasteurizing and bottling milk. It is hoped that we shall soon be able to provide half-pint bottles for all cafeterias.

Heavy wire crates, with a capacity of twenty half-pint bottles, are used in transferring milk from the plant to the kitchens. These crates are sturdy and can be stacked conveniently and safely in refrigerators. Bulk milk is conveyed to the kitchens in the regulation 5-gallon cans. Milk bottles, lettered with the hospital name at the time of manufacture, and especially designed and printed bottle caps are used.

As a constant check on bacterial count, regular tests are run on milk specimens as delivered from the producer and also on the bottled product.

Tests are run on empty bottles and cans in order to determine the efficiency of the washing and sterilizing process. These tests reveal most satisfactory bacteriologic counts in the various stages. For many months the maximum counts in the bottled milk ready for serving have failed to exceed 500 bacteria per cubic centimeter. A relatively low count in the raw milk has been maintained for the most part by the producers, with individual counts coming under 10,000 bacteria per cubic centimeter the greater part of the time. The standard milk ordinance of the United States Public Health Service classifies raw milk within this range as "good," and does not classify as "poor" milk anything that registers below 50,000 bacteria per cubic centimeter.

For infant feedings and formulas, Holstein milk is used as provided by one of the vendors. This milk gives a low butterfat content and is considered by our pediatricians as being the most satisfactory for this purpose. The larger percentage of milk received is from Holstein herds and ranges from 3.6 per cent to 4 per cent in butterfat content, which provides a suitable beverage milk without standardization. Milk received from Guernsey herds ranges from 4.5 per cent to 5 per cent butterfat content. Consideration is now being given to taking on a new producer with a Jersey herd, in which case arrangements will be made to separate the milk and produce cream, or perhaps standardize with other milk in order to provide a beverage milk of not too high butterfat content.

A general summary of the cost of operation for a year will doubtless be interesting, so the detailed cost report ending June 30, 1936, is in the accompanying table.¹

¹Read at the convention of the American Hospital Association, Cleveland.

THE HOUSEKEEPER'S CORNER

• There is good news for housekeepers in a message from Dr. Mary deGarmo Bryan, head of Institution Management, Teachers College, Columbia University, that special sections of two courses in the institution management department will be arranged for them during the spring session. Approximately twelve two-hour periods beginning about March 1 in the courses on organization and management, and on furnishings and equipment will be devoted to topics which will be of help to housekeepers particularly. Outstanding housekeepers in the hospital and hotel fields will cooperate in giving the courses. Students with education and experience satisfactory to the instructor may arrange for special registration for this series of lectures. Field practice will be arranged for summer months in institutions cooperating with the college. Further information may be secured by writing Dr. Mary deGarmo Bryan at Teachers College, Columbia University, New York City.

• Closer affiliation between the Connecticut chapter of the NEHA and the Connecticut Hospital Association has been effected by the invitation of the hospital group to the housekeepers to attend their meetings regularly. Blanche I. Newton of Grace Hospital and Evelyn L. Coolidge of New Haven Hospital were introduced at the Hartford meeting as representatives of the chapter. Work has already been started on a study of floors, which will keep the housekeepers occupied during the winter months. This will include kinds of floors, treatment and maintenance.

• And other interesting news comes from the Connecticut chapter! Mrs. Gladys Hancock, who organized the chapter and served as its president for the first year, 1935, has resigned her post in charge of housekeeping in the Sterling Nurses' Dormitories, Yale School of Nursing, to accept a position as director of housekeeping in the New Britain General Hospital, New Britain, Conn. Mrs. Hancock was formerly associated with the Middlesex Hospital in Middletown, Conn., and the Hartford Municipal Hospital, Hartford, Conn. She has been active for years in promoting better standards in housekeeping and last year attended the training course at Cornell University.

• Members of the Chicago chapter of NEHA held their Christmas party on December 17. "Twenty-four new members since last April" was a pleasing announcement made by the treasurer. The chapter is now the second largest and aspires to head the list. The president announced that the annual meeting of NEHA would be held in Cleveland in May.

from **BELLINGHAM, WASH.**
to **KEY WEST, FLORIDA**



NON-SLIP FLOORS NOW A FACT!

Thousands of the biggest units in the country, after months of research have found that THE MYCO METHOD OF FLOOR MAINTENANCE has made non-slip floors an accomplished fact!

This service is available to hospitals now through factory-trained service men located all the way from the tip of Florida to the uppermost corner of the Pacific Coast states.

Most hospitals having several types of floors will be interested to know that there is a MYCO METHOD for every type of floor; and in each case the non-slip quality is assured. Through this method you not only get a safe floor, a better-appearing floor, but you get it with a decreased cost of maintenance.

Write today that a local Mycoman may make a survey in your hospital and show the famous Myco guarantee of non-slip floors.

Masury-Young Company
76 Roland St., Boston, Mass.

NEW YORK OFFICE
 214 East 37th St.
 New York, N. Y.

CHICAGO OFFICE
 437 W. Ontario St.
 Chicago, Ill.

LOS ANGELES OFFICE
 156 W. 12th St.
 Los Angeles, Calif.

ATLANTA OFFICE
 175 Spring St., S.W.
 Atlanta, Ga.



System in Handling Linen

By Blanche I. Newton

DO YOU keep records? Whenever the superintendent asks for accurate information can you give it in a few minutes? If you do and can, you have gone far and done much to command confidence. Figures are impressive especially if they prove and it is the housekeeper's business to see that they do.

Furthermore, unless records are kept, how can you compare one month or year with another? How do you know when your consumption is excessive? How can you make out a budget for the next year?

For the purpose of discussing the system of handling the linen in Grace Hospital, New Haven, Conn., three headings are designated, and under each is listed the records from which all information is taken: (1) Discards—daily report, monthly tabulation by articles, monthly report (called discards and circulation), yearly tabulation of articles by months; (2) Circulation or Replacements—requisitions (sewing room to departments), file cards (alphabetically arranged), monthly report (discards and circulation), yearly tabulation of articles by months; (3) Control of Circulation.

First let us consider discards. A calendar book is kept in the sewing room in which are listed the articles no longer of use. Every day or so these are transferred to a monthly sheet, a vertical column per article. This is totaled at the end of each month.

On this sheet is the number of working days, which divided into the total gives the average total discards per day. This is watched most carefully during the month.

The figures from the monthly tabulation sheet are now listed on a report of articles discarded, alphabetically arranged, called "Discards and Circulation." The headings are by departments with subheadings by floors. For example:

- Medical and Surgical
 - Private Pavilion 1
 - Private Pavilion 2, etc.
 - Main Building 1
 - Main Building 2, etc.
 - Children's Pavilion
 - Surgery
 - Obstetrical
 - Sterile Supply
 - Dispensary
 - Classroom
 - Nurses' Home
- Dietary
- Physiotherapy
- X-Ray
- Laboratory
- Housekeeping

These same figures from the "Discards and Circulation" report are also listed by months on a twelve-month columnar sheet. At any time during the year we can tell what the total discards have been to date and this information is occasionally used in connection with inventory. (Inventory January 1, plus circulation minus discards equals inventory as should be to be compared with the physical inventory as taken.)

At its best the discard report is only a guide, but experience has shown what usually does not get to us for discard (wash cloths, diapers, towels, etc.) and in such cases we depend upon our past records showing average quantities replaced per month.

Now for circulation. With the report, "Discards and Circulation" as a guide, requisitions (which must all be signed by the receiver) are made for departments or floors and linen is delivered from the sewing room stock.

Two postings are made from each requisition:

- a. To circulation file cards, articles arranged in alphabetical order.
- b. Memoranda pencil figures of each article delivered beside the respective monthly discard figures on the twelve-month columnar sheet. This has been found to be a great time saver—at a glance it may be detected if replacements do not equal discards.

Requisitions Priced Monthly

At the end of each month the requisitions are priced, the total of which must substantiate the total charges against departments.

Once a month file cards are totaled, the number of each article for the month being transferred to the "Discard and Circulation" report where they are priced and extended by departments and these totals must agree with the total of the requisitions above.

The money value of this circulation report is used by the office as the basis of charges to departments, on the hospital books.

The circulation figures on the "Discard and Circulation" report are also listed by months on a twelve-month columnar sheet. They are valuable in inventory work and the yearly total is important for comparison purposes.

As a precautionary step the file cards of those articles procured from the hospital general stores are checked against the store charge to the housekeeping department. This verifies receipts by the department and deliveries of other departments.

Finally, control of circulation. After much study a plan has been adopted to take the control of the linen from the linen room. Instead it is in the housekeeping office and the advantages are apparent.

All linen in the hospital is marked by departments or floors. A quota for each floor, according to the number of beds and the classification of service, was set by the supervisor of nurses. The linen room girl is the sorter in the laundry and no additional help in that department was necessary. A truck or basket was marked for each floor and is placed near the sorting table, convenient to receive the finished linen as it comes through. This has eliminated a considerable amount of handling.

Some of the advantages are: (1) reduction of number of deliveries from two to one a day, (2) return of linen daily to the ownership floor or department, (3) elimination of work in making out afternoon linen lists, (4) possibility of tracing damages and losses to a specific floor, (5) correction of excess and shortage by floors and (6) a dependable inventory.

Housekeeper Shows Ingenuity

A search of the cellar and a small sum to spend—that's what it takes to make a cheerful recreation room out of a bare porch.

At any rate Louise Leturc, executive housekeeper at Fulton House, the Bronx Hospital Nurses' Home, carried out this transformation. She rescued from abandonment a chair covered in old-fashioned brocatel, two small kidney shaped tables and a wicker lamp, had these painted in a color scheme of deep cream with a burnt orange trim, added two new willow chairs, three India rugs with figures of burnt orange, green and yellow on brown, and something charming in the way of a nurses' lounge began to take shape in what had hitherto been an uninviting porch.

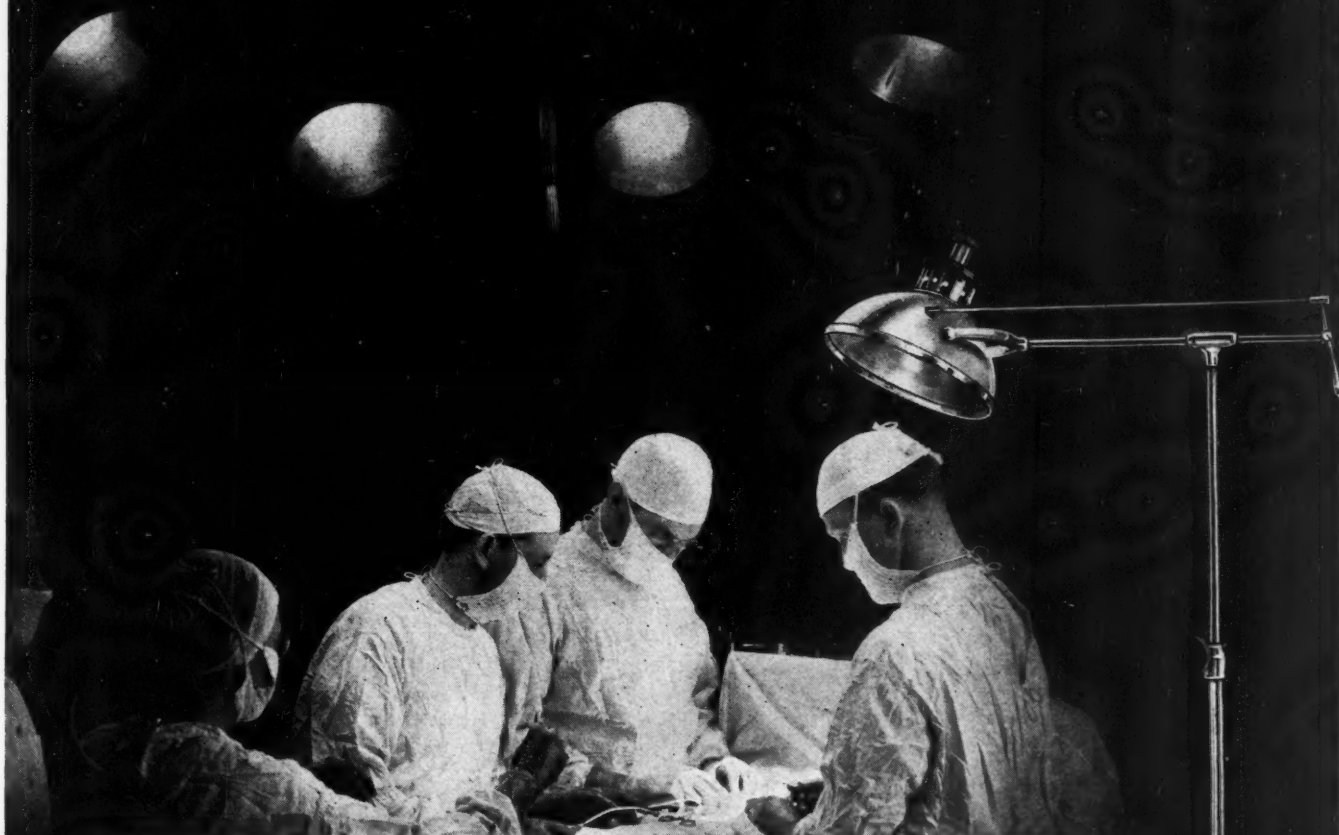
When the ceiling had been calcimined, the woodwork scrubbed and the floor painted a dark mahogany and waxed, she introduced wall pockets of glass on either side of the French windows and planted these with ivy and snake plants. A wicker center table was used to hold a gay plaid box of creeping ivy and the lamp, whose shade was lined with gingham of matching colors. Pillows covered in brown plaid with yellow and white stripes, and table runners of monk's cloth trimmed in a worsted running stitch of contrasting colors completed the picture.

The room was a favorite place of relaxation during the summer months, Miss Leturc found. Her recipe is a portion of imagination, a portion of ingenuity and a dash of money.

A CASTLE *Spotlight*

SUPPLEMENTS

INADEQUATE ILLUMINATION



● SURGEONS never complain of inadequate illumination in the operating room equipped with a Castle Spotlight. Supplementing your present system (until such time as you can get a new Major Castle operating unit), the Castle Spotlight throws a cool, intense, shadow-reducing beam of illumination, giving true tissue values. Although this spotlight yields over 2500 foot candles, there is but 2° F. rise noted on the operating field. The Castle Spotlight is fully adjustable. The ideal supplement to any system of operating illumination. *Write for interesting illustrated booklet "Effortless Vision".*

WILMOT CASTLE COMPANY

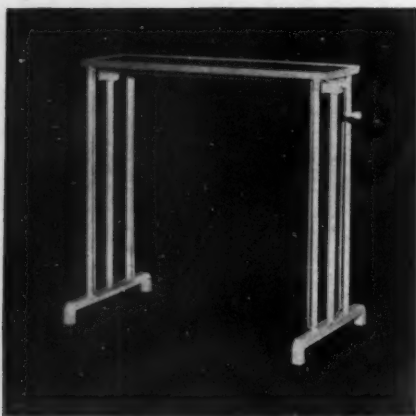
1271 University Ave.

Rochester, N. Y.

Approved by American College of Surgeons

Adapted to Brain Surgery

By Charles E. Remy, M.D.



The table at minimum height.

FOR the greater convenience of the surgeons of its staff when they are doing head or brain surgery, the Minneapolis General Hospital, Minneapolis, has developed a new style of instrument table or stand. No originality is claimed for the idea itself, which was gleaned from an instrument table which has been in use at the Mayo Clinic in Rochester, Minn., for some time.

The table used in the Mayo Clinic is one which is understood to have been devised there and constructed in the shop at the clinic. The table here described is merely considered to offer slightly greater convenience in flexi-

bility of adjustment. It is also thought to possess the further virtue that it may be purchased from one of the regular manufacturing houses at a moderate price by smaller hospitals which may not have adequate shop equipment for manufacturing such furniture.

The table, for all of its convenience to the surgeon, is in fact merely a modification of a standard overbed table such as is used in many hospitals for the serving of meals to patients. The usual tilting center section has been omitted. The rubber inlay of the entire table top has likewise been left out, thereby providing a raised edge on all four sides of the table which serves to prevent the instruments from sliding off when the table is in use.

The average overbed table usually has a maximum height of about 44 inches and a minimum height of 30 to 32 inches, but these measurements have been modified for the new instrument table to the degree that it has an available maximum height of 72 inches but can be lowered only to a minimum height of 45 inches. Aside from the few modifications mentioned it is nothing more or less than an ordinary, crank adjustable, overbed table.

When not required for an operation, it can be lowered to its minimum

height and utilized as an ordinary operating room supply table.

The surgical staff of the Minneapolis General Hospital reports favorably upon this table in connection with head surgery of all sorts, and particularly as regards its convenience as an instrument table when brain surgery is being performed. Surprising to relate, and equally unforeseen when the table was originally planned, the general surgeons, the orthopedic surgeons and others are daily finding new uses for this table in connection with their surgery and have unanimously voted it to be an indispensable item in a modern operating suite.

Care of Bedding

Sheets and pillow cases should be carefully handled in the linen room as well as on the various floors. Mending should be promptly attended to and should be done before any article is sent to the laundry.

A large proportion of the wear to which bed linen is subjected is received in the laundry and it will be time well spent to check on how your linen is treated there.

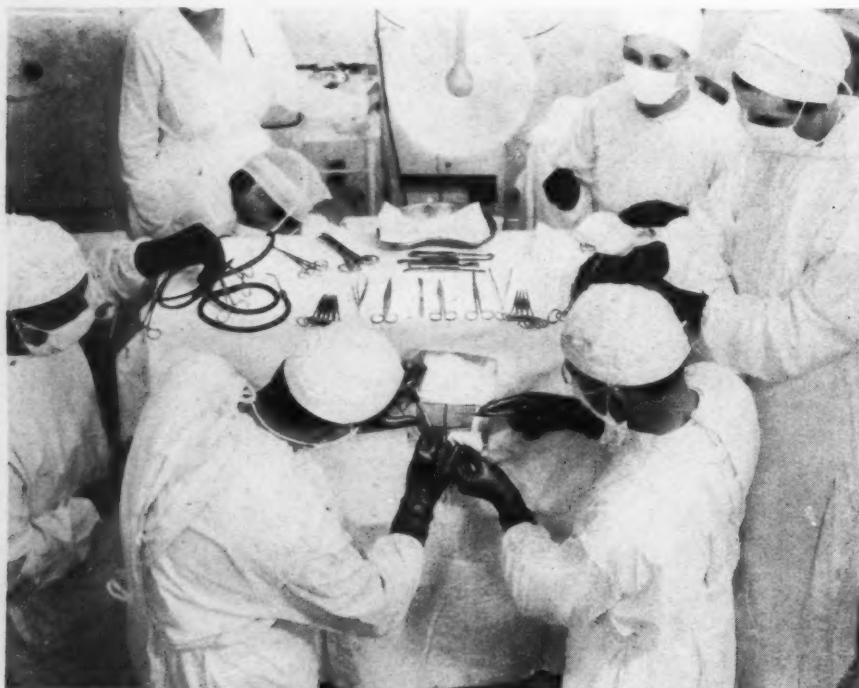
Pillows may be kept fluffy and as a result will give longer service if a strong current of air is occasionally blown through them with the blower attachment of the vacuum system. This will also serve to keep them dust-free.

Mattresses must be turned over and changed end for end at frequent intervals to ensure proper service. In storage they should never be piled one on top of another for any length of time but should be placed in individual racks. When in use they should be thoroughly vacuum dusted at least once weekly and torn apart, reuffled, sterilized and remade at three to five-year intervals.

Blankets, whether of the all-wool or part-wool variety, should be kept in a fairly airtight room, the air of which is permeated with fumes from an open container of carbon tetrachloride placed on the top shelf to protect them from the ravages of moths.

Improvements in Floor Wax

The process of manufacturing water wax has been so greatly improved within the last few months that the best water waxes no longer water spot. Some of these new water waxes will show a dull spot whenever water stands for a time but some show almost no loss of gloss. Most of those that showed loss of gloss because of water regained their original luster after a brief buffing. These latest tests show that there need no longer be any hesitancy in finishing rubber floors with any one of several makes of water wax put out by the more progressive manufacturers.



New instrument table in actual use.

BAXTER'S ARE THE PIONEER SOLUTIONS

IF YOU will but turn that over in your mind, there will come a recognition of the reasons why Baxter's are so famous. Baxter was the pioneer. Baxter's straddled its job and rode it hard. . . . Made its name world famed, because it gave to physicians perfect solutions . . . solutions as correct and as uniform and as fine as they would have made them themselves had they the time and the surety and Baxter's modern laboratories. Baxter's was first and Baxter's have always been first in all things pertaining to intravenous therapy. Baxter's, the pioneer, are perfect solutions in perfect dispensing containers.

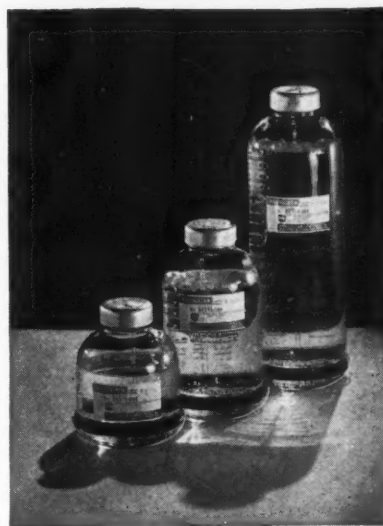


BAXTER LABORATORIES, INC.

Glenview, Ill.

Glendale, Calif.

College Point, N. Y.



THE BAXTER VACOLITER, unique dispensing container for Baxter's Solutions, has been patented beyond all ability to copy.



The Pioneer Intravenous Solutions

Distributed East of the Rockies by

AMERICAN HOSPITAL SUPPLY CORPORATION

Chicago

New York



The Baxter Vacoliter has the approval of the American College of Surgeons.

FOOD SERVICE

Conducted by Anna E. Boller, Rush Medical College

Silver—For Beauty and Use

By Anna E. Boller

Five points to remember:

1. Select good silver.
2. Select appropriate dishes and patterns.
3. Take good care of it.
4. Have only badly worn pieces replated.
5. Have replating done by a reliable firm.

AS CIVILIZATION advanced and man began to appreciate the finer things in life, his attitude toward eating changed. To primitive man, eating had been one of life's necessities and little thought was given to the food itself or the way it was eaten. Man ate what he could get whenever he could get it, without any ceremony.

As standards of all activities of life were raised, man found that certain implements were helpful in his way of living. Knives were needed for dividing the spoils of the hunt. At first, crudely fashioned from stone, they were gradually refined through the ages, until metals such as bronze, iron and finally steel were used by master craftsmen to make knives both practical and artistic. No one knows whether or not early knives were used when eating, though it seems reasonable to suppose that they were. We do know, however, that they were not generally used until the Middle Ages.

The use of the spoon antedates that of the knife by many centuries. The population of the world was concentrated along large bodies of water, and men found shells convenient in eating certain types of food. They found that shells were easier to use when they had handles, and fashioned wood and bone handles for them, producing an implement much like the spoon of today. Wooden spoons were

also in early use, probably a natural development from the use of flat or hollowed pieces of wood in eating. As man developed his knowledge of metals, it was only natural that this important table utensil should have been made from them—bronze and gold probably being the first metals used.

While it is hard to place the origin of two of our important table tools, the history of the use of the fork may be definitely traced. We can assume that it was first used as a weapon because it is so often associated with mythological characters. We find that in the seventh century it was used in connection with food—but only in the serving of it, not the eating. The first fork, probably one or two pronged, was used to hold food over the fire.

No doubt food was eaten from this fork, but we do not find it on the table until the early sixteenth century, when it appeared in Italy among a few of the nobility and upper classes.

Eventually all three utensils were found essential for table comfort, but in the early days the hostess did not have to worry about her silver as

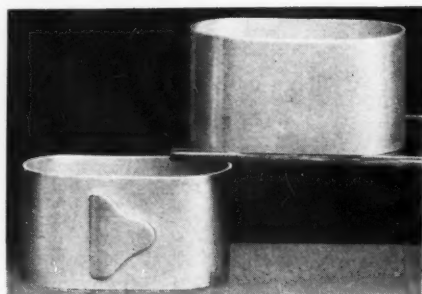


Silver sherbet dish.

guests brought their own. These were often elaborately designed contraptions, such as a fork with a spoon at the other end or a folding spoon. Silver became the common metal used, but it proved too soft and an alloy of silver and copper (925 parts of pure silver and 75 parts of copper) now known as sterling silver, was found to combine the beauty of silver with the necessary strength of copper.

This precious metal was too expensive for use in many homes and in institutions. With the discovery of a way to put silver upon another metal, silversmiths developed a fine product with a sturdy base and enough silver plated on to it to make it appear as attractive as that made from pure silver. This type of eating utensil has been adopted by institutions everywhere as the most practical and economical to use.

The many grades of service silver available make it possible for an institution to select the one best suited to its needs on the basis of use, cost and durability. To determine the silver which will best serve the needs of an institution, one must know something about its production, the method used in defining the various



Napkin rings have a place for the card bearing the patient's name.

qualities and the interpretation of the specifications presented by the companies catering to the institutional field.

Good silver is necessary for the comfort and convenience of patients as well as for the efficiency of food service. It seems to be generally accepted that the best base for sturdy and attractive flatware is an 18 per cent nickel silver alloy. Hollow ware is better when made of 21 per cent nickel silver.

The types of plates put upon this base vary greatly—depending upon the amount of silver deposited. Some of the plates generally available are triple plate, five-ounce plate, half plate, extra plate and sectional hotel plate.

Triple plate is about three times as heavy as standard plate. This guarantees that 240 pennyweight (5,760 grains or 1 pound) of pure silver is deposited upon each gross of tablespoons or forks.

Five-ounce plate is more than 25 per cent heavier than standard. As the name implies, it assures that 100 pennyweight (2,400 grains or 5 ounces) of pure silver is deposited upon each gross of tablespoons or forks.

Half plate, as the name implies, is half as heavy as the five-ounce plate, 50 pennyweight (1,200 grains or 2½ ounces) of pure silver being used for each gross of tablespoons or forks.



**An Accepted, Highly Effective
Milk Modifier... at an
Approximate Cost of**

**2¢
PER DAY**

ON THE basis of tested and approved feeding schedules averaged for babies up to the age of nine months, one tablespoon of Karo would be used with about 6 fluid ounces of milk. On this basis, a one and one-half pound tin of Karo (which sells in grocery stores for about 12c) will furnish the necessary amounts of easily assimilated carbohydrates, dextrin, maltose and dextrose,

for 6 quarts of whole milk. Probably no other infant food of equal acceptance is available at such low cost as Karo.

Mothers, generally, will appreciate their doctors' suggestion of Karo as an effective, economical milk modifier.

Karo is accepted by the Council on Foods of the American Medical Association.

★ Infant feeding practice is primarily the concern of the physician, therefore, Karo, for infant feeding, is advertised to the Medical Profession exclusively.

For further information, write H-1,
CORN PRODUCTS SALES COMPANY, 17 Battery Place, New York, N. Y.

Extra plate assures the purchaser that the articles have an extra amount of silver deposited on the spots which receive the most wear.

Sectional hotel plate is heavier than other plate because the blanks or base metal utensils used are heavier. Although the least expensive and most durable product, sectional hotel plate is not practical for hospital use because it is heavy and looks clumsy on a tray.

For most uses, the best plate is probably the most economical in the long run, if the original cost can be met, if the institution does not have too great a loss and if proper care is given to the silver.

In regard to construction, no soft soldering should be accepted, for durability is greatly increased when blades of knives are hard soldered to the handle and when all hollow ware is put together in the same way. In the latter, articles that are seamless with rounded corners are superior to those with seams. They can be kept clean with less effort.

Proper care is essential if the greatest amount of wear is to be obtained from silver. Keeping silver clean is most important, not only from the standpoint of sanitation but also from the standpoint of increasing its period of usefulness. Food allowed to dry on silver makes washing much harder. The harder the washing, the more wear on the silver. The first rule in any food service department, in connection with dishwashing, should be—"Wash all silver immediately."

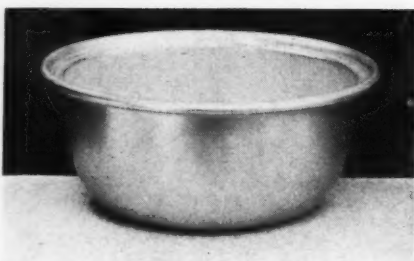
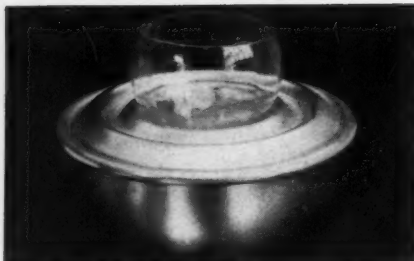
Besides being kept clean, silver should be kept well polished, because a bright, clean piece of silver both adds to the attractiveness of the tray and increases the appetizing appearance of food. Polishing machines simplify this work, but many institutions find that they can keep the silver in condition with a good polish applied by hand. The best guide to



Divided luncheon plate.

the care of silver will be given by the silver company from which it is purchased, as this organization is naturally desirous of having its product give the greatest possible satisfaction.

Dietitians are constantly interested in avoiding a crowded tray. Silver companies catering to hospital trade have with this in mind developed



Combination bowl has many uses.

many pieces that are compact and take up less space on the tray, thus making it more attractive. They have also designed combination dishes which serve several purposes, thus reducing the original cost as well as the need for storage space. Flat topped dishes, too, have this last advantage.

Combination bowls may be used covered or uncovered for soup or cereal. The addition of a ring or tripod turns them into attractive dishes for serving fruit juices, fruit cups, ice cream and fish cocktails.

Divided luncheon plates are designed with or without hot water containers. With the hot water containers, food is always served hot. Without this heating unit, the dishes may be well heated, thus assuring that food will be hot if served promptly. In either case the meal may be served attractively without extra dishes to clutter the tray.

Silver sherbets offer two advantages. If they are thoroughly chilled, fruits or ices served in them will remain cool. Their stand is smaller than a china fruit dish, and fits under the edge of other dishes.

Napkin rings with a place for the card bearing the patient's name and room number do away with the menu holder, so necessary to assure correct room service. This makes one less article on the tray. These may be had with slots into which cards are inserted, or with clips which hold the card.

Special sugar dispensers and especially designed coffee pots make the tray more attractive and save space.

Much has been said for and against replating silver, from an economical standpoint. When plating is done wisely, it not only assures attractive service but is really an economy. The problem in having silver replated is to get what one pays for.

Reliable plating companies are bound, by business ethics, to give just what they bargain to give. But the questions are—which are the reliable houses, what can a plating company do to cheat a customer, and finally, how can a customer find out whether he has received what he ordered?

Beware of "Too Low" Bids

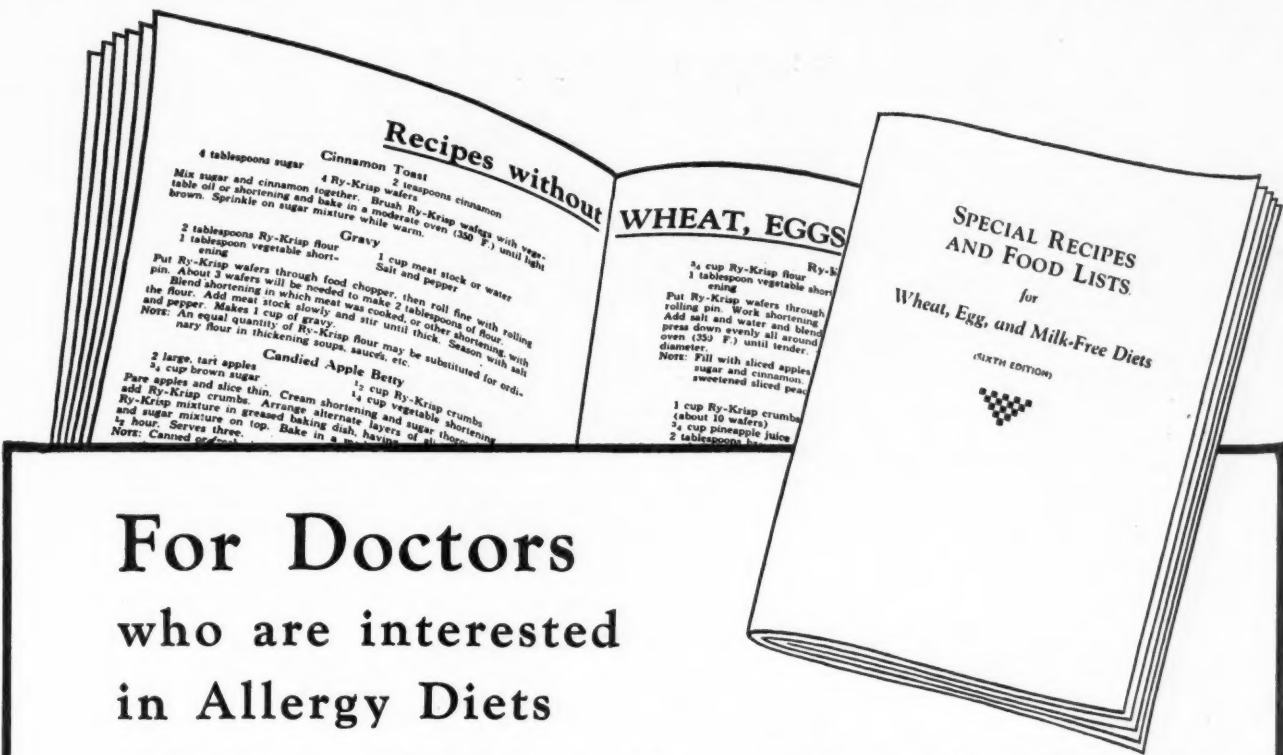
The first question can be answered only by a warning to investigate the company and beware of "too good" prices. A firm that gives a low bid can, without the customer's knowledge, skimp the job in any of four processes. The first is in the mending. Soft solder does not wear and should not be accepted. The second is in the plating. All silver should be removed before the new silver plate is applied. Stripping the silver is an extra operation that increases the cost, but if it is not done the new plate on top of the old is likely to blister and peel, thus shortening the life of the plate. Then in the actual plating, the time allowed in the plating tank can be shortened, thus reducing the amount of silver deposited on the base metal. Lastly, the finishing may be cheapened. A hand burnished finish is well worth the extra cost, for it works the silver into a hard, bright and durable finish. Machine burnishing makes the silver look just as well, but does not give the wearing quality of the hand finish.

The question of how to determine whether or not one has received what was ordered is harder to answer. The only absolute way, and one which might pay if a large quantity of silver has been replated, is to send a piece to a laboratory and have the silver removed and weighed. This is an added expense, and might be avoided if care is taken in selecting the company to do the work.

If replating is to be done, the pieces to be repaired should be selected with care. It is wasteful to send silver which is not badly worn. Watch the silver, and as a few pieces appear to be worn, send them to be repaired. This will hold down replating bills.

Acknowledgment is gratefully made to the silver firms who contributed material and pictures for this article, and to Arnold Shircliffe, for his help on the subject of replating.¹

¹Additional information on the selection of silverware will be found in *The HOSPITAL YEARBOOK*.



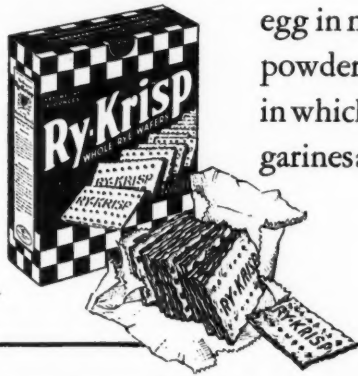
For Doctors who are interested in Allergy Diets

... here's a helpful diet and recipe booklet

With this booklet your patients can more accurately follow the wheat, egg or milk-free diet you prescribe. Planned with the aid of leading allergists and dietitians, it provides complete lists of allowed and forbidden foods. Also practical advice to help patients guard against such common food anomalies as the wheat flour in rye bread, the

egg in many baking powders, the milk in which many margarines are churned.

These books are for professional use and distribution only. None are ever distributed to the laity. In examining the booklet, you will find that Ry-Krisp is frequently used in the approved recipes. That's because these wafers—made of flaked whole rye, salt and water—are perfectly safe. Besides, because of their brittle-crispness and unique flavor patients gladly eat Ry-Krisp as bread at every meal. For free samples and Allergy Booklets, use the coupon below.



RY-KRISP WHOLE RYE WAFERS

RALSTON PURINA COMPANY, Dept. MH, 1873 Checkerboard Square, St. Louis, Mo.

Without obligation, please send me samples
of Ry-Krisp and Allergy Diet Booklets.

Name _____ Address _____

City _____ State _____

(This offer limited to residents of the United States and Canada)

In Accordance With Kosher Law

By Irma E. Reaves

A MOSHGIACH, or Rabbi, and three dietitians supervise all of the kosher food prepared at Mount Sinai Hospital, Chicago. With the exception of a few therapeutic diets, all food for patients and personnel is kosher—an average of about 1,000 meals a day. The duty of the Moshgiach is to see that the kosher dietary laws are strictly adhered to and that the patients are well satisfied.

The meaning of the term "kosher" implies much more than just the manner in which the animal is killed, and many variations in the preparation and serving of food are necessary before it can be considered kosher.

All food comes under one of three classifications in the Jewish dietary laws: meat, dairy or neutral. Meat and milk are never served in the same meal, but neutral foods may be served with either. At Mount Sinai dairy meals are served in the morning and evening, and a meat meal at noon, these being accompanied by neutral foods, such as eggs, fish (only fish that have scales are used), vegetables, fruits, jellies, nuts, candy, tea and black coffee.

Bread is neutral if prepared with water and dairy if prepared with milk. The neutral bread is used throughout and purchased from a kosher bakery.

However, when hot breads are used at a dairy meal they are baked at the hospital. All cakes are baked by the pastry cook at the hospital. Cakes used at a meat meal are baked with water instead of milk and vegetable compound is used instead of butter, otherwise the same ingredients are used, as they are neutral.

To carry out further the kosher "dairy and meat" meals two separate kitchens are necessary, each completely equipped with gas ranges, steam tables, ice boxes, bains-marie, dish warmers and sinks. Utensils for each kitchen are marked with steel tags indicating "meat or dairy." There are also two sets of dishes and silver, different patterns making it a simple matter to keep the sets separate. Glassware is neutral and may be used with any meal.

At Passover new dishes and utensils are purchased, as dishes that have been in use throughout the year are not permitted to be used at this time. Chinaware and utensils that have wood on them in any way, such as knives, strainers and pots with wooden handles, cannot be sterilized. However, silver and aluminum utensils can be sterilized and are used at Passover. Careful thought is given to the purchasing of equipment and rarely is a

piece purchased that cannot be sterilized with the exception of such things as knives and strainers.

The sterilization of kitchen utensils at Passover is under the supervision of the Moshgiach. The kitchen and serving rooms are thoroughly cleaned, walls are washed and the kitchen is usually painted. Any equipment that cannot be sterilized is packed and stored away until after Passover, when it is brought out and put into use again. The equipment purchased for Passover is used for replacement throughout the year.

Separate Dishwashing Units

Dishwashing is centralized. There are two separate units, "meat and dairy," and each is equipped with a dishwashing machine, double sinks and metal tables. Under no consideration are meat dishes ever washed in the unit used for dairy dishes. In washing dishes, glassware, pots and pans, no soap is used, as soap is not considered kosher. There is a kosher soap on the market which is used frequently in kosher homes, but we find it expensive and instead use specialized cleaners. They are noted for their purity, are 100 per cent inorganic—entirely free from soaps and grease—and are found to be most satisfactory.

Kosher dietary laws are rigidly adhered to throughout the purchasing, preparing and serving of all food. In regard to meats, the only animals used are the cow, lamb and veal, and they



In the main kitchen trays are being set up for the noon meal, which is a meat meal.

CONSERVATION OF ESSENTIAL ELEMENTS IN PROTECTIVE FOODS

I. MINERALS

● Considerable differences may exist between the mineral contents of foods from both the qualitative and quantitative standpoints. In fact, variation in mineral content has been noted even in the same plant variety; such variations being dependent, among other factors, upon soil or climatic conditions (1).

A striking example of the influence of one of these factors is the relative richness in iodine of field crops raised in certain coastal regions of this country where the soil is also high in iodine.

From the point of view of those concerned with human nutrition, interest in the mineral content of the food supply is usually centered around calcium, iron and iodine; since it is generally agreed that of all the essential minerals, these are the ones most apt to be inadequately supplied by the average varied diet. Conservation of these minerals in foods is, therefore, a matter of considerable practical interest.

Unlike the vitamins, minerals are not lost during storage of fruits and vegetables. However, solution losses during cooking may be severe, due to the fact that most minerals, as they occur in the plant, are soluble, or at least are extractable, by the water in which they are cooked. For example, cabbage cooked by the usual home method has been shown to lose from 21 to

72 per cent of its calcium (2).

As exemplified by these studies, solution losses of minerals in leafy vegetables are usually high. Losses in vegetables as a class are not, however, so excessive, as indicated by an average reported loss of 19.5 per cent of the calcium in seven common vegetables (3).

The average decrease during cooking in the ash content of five common vegetables has been found to approximate 37 per cent (4).

While the extent of mineral loss during ordinary home cooking methods will vary with the particular element under consideration as well as the food in which it is contained, sufficient evidence is at hand to indicate that such losses may be considerable. It is further apparent that discarding the cooking water—the usual home practice—entails a loss of valuable, essential mineral components of food.

Modern practice in commercial canning goes far in preventing these solution losses of minerals. Canned foods are cooked by the heat process accorded them while still contained within the hermetically sealed can. A minimum of water is used which also remains within the can, conserving for the consumer's use those extractable essential mineral elements which may be lost to the cooking water during home preparation of market varieties of foods.

AMERICAN CAN COMPANY

230 Park Avenue, New York City

(1) 1936 J. Nutrition 11, 55.

(2) 1936 J. Home Econ. 28, 18.
1925 Ibid, 17, 265

(3) 1935 J. Home Econ. 27, 376
(4) 1917 Amer. J. Dis. Child, 14, 34

This is the twentieth in a series of monthly articles, which will summarize, for your convenience, the conclusions about canned foods which authorities in nutritional research have reached. We want to make this series valuable to you, and so we ask your help. Will you tell us on a post card addressed to the American Can Company, New York, N. Y., what phases of canned foods knowledge are of greatest interest to you? Your suggestions will determine the subject matter of future articles.



The Seal of Acceptance denotes that the statements in this advertisement are acceptable to the Council on Foods of the American Medical Association.

must be killed by a Rabbi. The fore-quarter, through the twelfth rib, is the only part of the animal that is put to use.

When meat is delivered to the hospital it is checked by the Moshgiach, as well as the receiving clerk. The meat is koshered by a kosher butcher approved by the Moshgiach as having a thorough knowledge of koshering meat. During this process certain veins are removed. The meat is then soaked in cold water for thirty minutes, drained, and sprinkled with coarse salt. The salt is allowed to remain on the meat for one hour, then it is removed by rinsing three times with cold water. After this process

the meat is ready for use. There is only one exception to this rule, if the meat is to be broiled it does not have to go through the process of being koshered as broiled meat is permissible.

Kosher poultry is used exclusively. It is killed by a Rabbi and plucked dry, without scalding. All kosher meats are much more expensive than non-kosher, due to the extra labor involved in killing and handling.

A vegetable compound is used in most of the cooking, also a vegetable oil, since both are neutral. However, beef suet and chicken fat are used in preparing some of the meat dishes, and butter in some of the dairy dishes.

Water ices and ice cream are used

quite frequently. The company from whom these items are purchased has a special set up for making kosher ices and ice creams for kosher institutions. The mix and the handling of these products have been approved by the Rabbis. There is no gelatine used in the mix, since gelatine is not considered a kosher product.

All special diets are calculated and served at the same time as other trays. There are no exceptions made, other than in severe cases of therapeutic diets, such as ulcer and similar cases. When these trays are required they are prepared and served from the special diet kitchen after the other trays have been served. This is only the case at noon when the house is being served a meat meal, otherwise all special diets are served at the same time as the regular trays. These trays are collected and they are washed separately.

The accompanying kosher patient menus for one week give an indication of the type of foods served.

KOSHER PATIENT MENUS FOR ONE WEEK

Breakfast		Dinner	Supper
MONDAY			
Stewed Figs Grapefruit		Fresh Vegetable Soup	Cold Beet Borscht
Cereal		Chopped Liver Canapés	Au Gratin Cauliflower
Soft Boiled Eggs		Roast Beef	Duchesse Potatoes
Rolls		Broiled Lamb Chops	Peach and Raisin Salad
		Mashed Potatoes	Baked Custard
		Julienne Carrots	
		Hearts of Lettuce	
		Thousand Island Dressing	
		Stewed Pears and Cookies	
TUESDAY			
Orange Juice Baked Apple		Chicken Noodle Soup	Cream of Carrot Soup
Cereal		Fruit Cup	Tuna Fish Timbales, Mush-
Scrambled Eggs		Roast Veal	room Sauce
Toast		Assorted Cold Cuts	Buttered Noodles
		Browned Sweet Potatoes	Stuffed Celery Salad
		Pears	Pistachio Ice Cream
		Cabbage and Pineapple Salad	
		Angle Food Cake, Chocolate	
		Frosting	
WEDNESDAY			
Fruit Compote		Tomato Consommé	Cream of Celery Soup
Sliced Bananas		Assorted Hors d'Oeuvres	Baked Cheese Soufflé
Cereal		Baked Liver	Creamed Mashed Potatoes
Poached Eggs		Chicken Sandwich	Chinese Cabbage Salad
Toast		Baked Potatoes	Bread Pudding, Vanilla
		Asparagus Tips	Sauce
		Mixed Vegetable Salad	
		Apple Betty, Hard Sauce	
THURSDAY			
Stewed Prunes Fresh Pear		Mushroom and Barley Soup	Cream of Pea Soup
Cereal		Iced Tomato Juice	Creamed Eggs and Peas in
Soft Boiled Eggs		Boiled Beef Tongue,	Patty Shells
Rolls		Raisin Sauce	Baked Idaho Potatoes
		Lamb Stew in Casserole	Alligator Pear and Grape-
		Mashed Potatoes	fruit Salad
		Fresh Spinach	Strawberry Sundae
		Waldorf Salad	
		Lemon Meringue Tarts	
FRIDAY			
Orange Sections Apricots		Purée of Yellow Pea Soup	Cream of Potato and
Cereal		Mint Fruit Cup	Parsley Soup
Pancakes, Maple Syrup		Fresh Broiled Salmon	Fruit Plate, Assorted
		Gefilte Fish	Sandwiches
		Escalloped Potatoes	Carrots and Peas
		Buttered Cauliflower	Individual Cheese Cake
		Tomato Salad	
		Chocolate Pudding,	
		Whipped Cream	
SATURDAY			
Fresh Grapes Figs		Soup with Matzoth Balls	Cream of Asparagus Soup
Cereal		Two-Tone Cocktail	Broccoli, Hollandaise
Soft Boiled Eggs		Braised Beef	Sauce
Rolls		Broiled Veal Chops	Double Baked Potato
		O'Brien Potatoes	Salmon Salad
		Harvard Beets	Fruit Tapioca, Whipped
		Spiced Peach Salad	Cream
		Sponge Cake, Pineapple	
		Frosting	
SUNDAY			
Grapefruit Applesauce		Consommé with Julienne	Purée of Corn Soup
Cereal		Vegetables	Cheese Blintze, with Jelly
Soft Boiled Eggs		Anchovy Canapés	Broiled Potatoes with
Sweet Rolls		Roast Chicken, Giblet Sauce	Sour Cream
		Candied Sweet Potatoes	Tomato Salad
		Brussels Sprouts	Honey Cake
		Celery Hearts	
		Assorted Olives	
		Strawberry Ice	

RECIPES BY REQUEST

Submitted by

Phyllis Dawson Rowe

Dietitian, Johns Hopkins Hospital, Baltimore

Curried Vegetables (50 servings)

- 1½ quarts diced potatoes
- 1½ quarts diced carrots
- ¾ quart diced turnips
- ¾ quart green beans
- ½ quart celery rings
- 2 ounces fat
- 1 ounce flour
- 1½ quarts milk
- 4½ teaspoons salt
- ½ teaspoon curry
- 1½ teaspoons paprika
- 3 tablespoons parsley

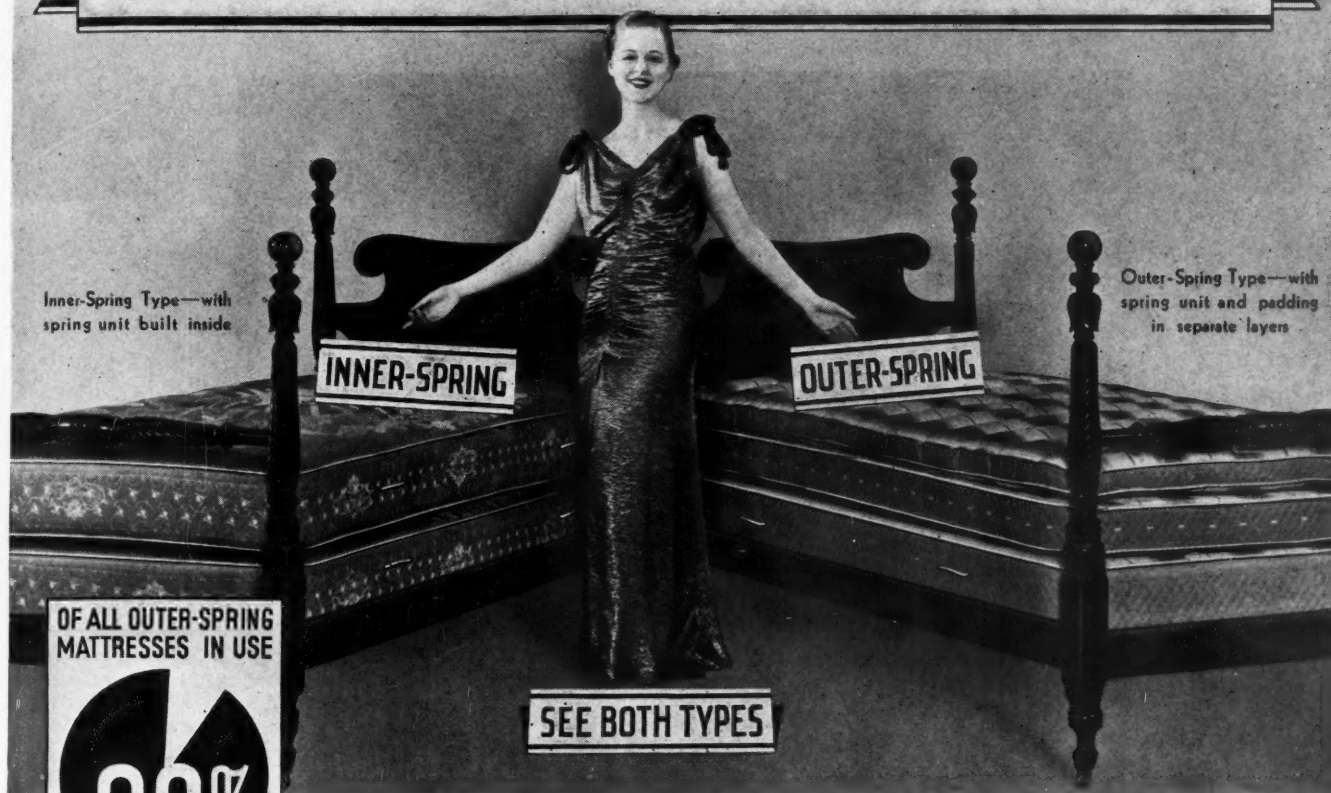
Make white sauce of flour, butter, milk. Combine cooked vegetables and add seasonings and white sauce.

Pittsburgh Potatoes (100 servings)

- 23 pounds potatoes, pared and cubed
- ¾ cup salt
- 4½ quarts white sauce
- 1 pound onions, finely chopped
- 1¼ pounds pimientos, finely chopped
- 1 pound butter or substitute
- 4 pounds cheese, grated

Cook potato cubes in boiling salted water for 10 minutes. Drain. Sauté onions in butter, add pimientos and combine with potatoes. Turn into buttered pans, cover with sauce, sprinkle with cheese and bake in moderate oven until potatoes are soft. Brown under broiler, if necessary

THERE ARE TWO TYPES OF MODERN MATTRESSES



OF ALL OUTER-SPRING
MATTRESSES IN USE

90%

ARE

Spring-Air

TRADE MARK
REG. U.S. & CAN. PAT. OFF.
CHARLES KARR COMPANY, HOLLAND, MICH.

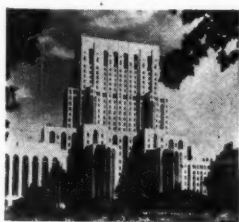
UNPREJUDICED FACTS...

of Special Import to all Hospital Superintendents

There are 3,000 bedding manufacturers who share the right of making both types of modern mattresses—inner-spring and outer-spring. Many of them do make *both* types. Yet, nine out of ten outer-spring mattresses in use are Spring-Air! . . . Why? . . . Because the records made by *all* competing spring units in this direct, out-in-the-open comparison prove the unquestioned superiority of Spring-Air's guaranteed Karr Spring Construction!

. . . Important as it is that the vital spring element be *right* in an outer-spring mattress, it is even more important that it be right in the inner-spring type where the spring unit is buried inside, hidden from inspection.

. . . Be sure to get the guaranteed Karr Unit no matter which type of mattress you buy. Then you will be following the example of the expert buyers in thousands of hotels and hospitals who demand all the comfort—all the endurance they can get for their money . . . Every Spring-Air Mattress—in either type—has the guaranteed Karr Spring Construction!



New York Hospital (Cornell) and hundreds more use and endorse Spring-Air. You'll always find that experts buy what experts build.



SPRING-AIR

General Offices: Holland, Michigan
44 Factories in United States and Canada

Spring-Air product standards are specified and, through inspection, maintained by the licensor, Charles Karr Company, Holland, Michigan, manufacturer of the spring elements used in completed Spring-Air products.

Private Room Tray



St. Luke's Hospital, Chicago, Frances B. Floore, Director of Dietetics.

Beans Bretonne Salad



Tomato
Romaine

Navy Beans

Parsley
Marinade

On a bed of romaine or lettuce place a scalloped, hollowed-out half of a ripe tomato. Fill center with cooked navy beans which have been marinated in a sauce made out of half brown (Espagnole) and half tomato sauce, to which has been added enough vinegar to give a decided smack or acidity. Sprinkle with chopped parsley. Serve with Thousand Island dressing.

The beans should be allowed to marinate from 4 to 6 hours. They should be placed in the marinade warm, so that they may absorb the flavor as well as some of the marinade. Drain beans well before adding them to the marinade. In place of the tomato basket, a heaping pile could be placed on a large slice of tomato.
—Arnold Shircliffe, Chicago.

FOOD FOR THOUGHT

- Mary Edna Golder, dietitian at St. Anne's Hospital, Chicago, tells of the purchase of a new truck for carting meats, vegetables and fruits from the market twice weekly. For the past five years an old car has been used for this purpose and this was found so successful that it was decided to purchase the truck. The butcher and the dietitian twice a month go to the market and select goods, thus preventing the need for returning purchases or accepting inferior goods.

- Doris T. Odle of Presbyterian Hospital, Denver, states that this hospital charges \$1 a tray for guest trays when they are served in the room but visitors are allowed to eat in the dining room at a much reduced price. In this way the hospital discourages the serving of trays in the rooms because of the extra time and trouble entailed.

- Members of the American Dietetic Association must have been justly proud of the letter sent out by the president, Lute Troutt of the Indiana University Hospital, Indianapolis. In this are outlined the many projects on which the four sections of the association are to work during the coming year. Surely every dietitian will find something in which she is interested, and to which she should lend her enthusiasm and support, by which is meant sharing in the work of the project. Elsewhere in this issue (page 63), Miss Troutt outlines plans for 1937.

- Spinach is probably in for another jolt. A year or so ago, Doctor Hart and Doctor Elvehjem of the University of Wisconsin placed spinach at the bottom of the list as a source of iron. Although its content of iron is high, the iron is only about 50 per cent available. Recent work done by the Children's Fund of Michigan indicates that it may be harmful to eat too much spinach because of its oxalic acid content. It appears that the oxalic acid combines with the calcium of the diet and turns it into a form which the human body cannot use.

- Requests have been received for information about ice cream mixtures. A brief article on ice cream was presented in the May, 1936, issue of this publication. This dealt mainly with cost. A more extensive article which discusses the flavor, body and texture of ice cream was presented in the February, 1936, number of *Practical Home Economics*. Anyone interested in making ice cream would certainly find this article valuable.

- The second edition of the nutritional charts prepared by H. J. Heinz Company is now available. These charts have been brought up to date and in a complete way give food values, especially food values of certain canned foods.



"MAGNOLIA"—a 32 inch Goodall print, chosen by Mr. Charles Wordell, superintendent of St. Luke's Hospital, Chicago.
From the Clark Linen Co.

"Singing" Windows AT ST. LUKE'S HOSPITAL, CHICAGO

THESE GOODALL DRAPERIES sing a song of cheer, for the patient—and the hospital-budget alike! They're bright, colorful, yet inexpensive and long-wearing. The fresh, good-looking print won't be dulled by sun or tub; the sturdy yarns refuse to crush or wrinkle—and shed dirt like well-trained sanitation experts.

Turn to Goodall for your varied needs... cubicle curtaining, sheer window casement cloth, smart bedspreads, draperies, upholsteries. *They're "what the doctor ordered" —to stand the abuse of institutional wear.*

Goodall-Sanford INDUSTRIES

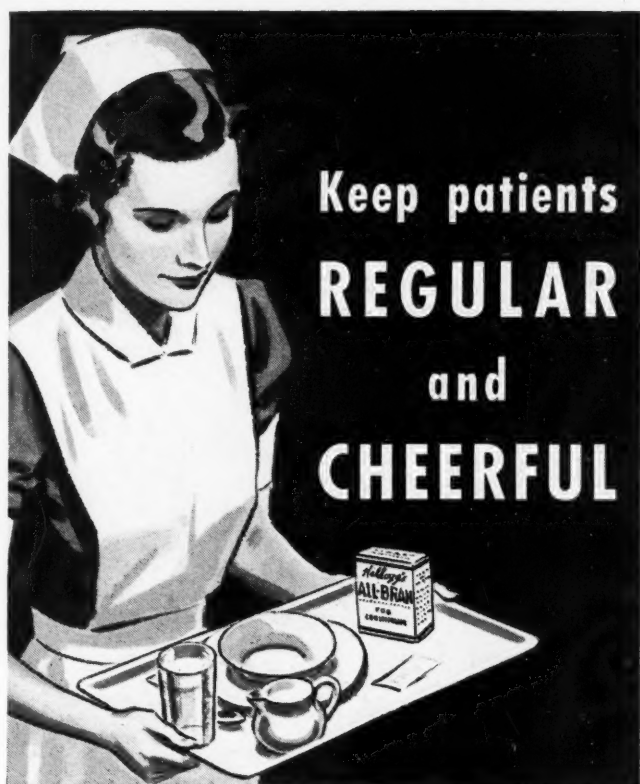
GOODALL FABRICS • VELMO UPHOLSTERIES • SEAMLOC CARPETS • LEATHERWOVE FABRICS

GOODALL-SANFORD INDUSTRIES, Fifth Avenue at 31st Street, New York City

February Breakfast and Supper Menus

By I. Leslie Hunter
Chief Dietitian, Bridgeport Hospital, Bridgeport, Connecticut

BREAKFAST			SUPPER				
Day	Fruit	Main Dish	Soup or Appetizer	Main Dish	Potatoes and Vegetables	Salad	Dessert
1.	Prunes	Bacon		Pork Chops	Escalloped Sweet Potato and Apple; Swiss Chard	Romaine, Spinosa Dressing	Strawberries and Sugar Cookies
2.	Grapefruit	Baked Eggs en Casserole	French Onion Soup	Crab Meat Salad Sandwich	Tomato Canapé; German Style Wax Beans	Preserved Figs With Orange Sections	Date and Nut Loaf
3.	Oranges	Sautéed Poultry Livers		Chicken With Fricassée Sauce in Baked Potato Cases, Border of Mashed Potatoes	Belgian Carrots	Princess Salad (Tomato, Asparagus)	Fresh Pineapple and Malties
4.	Prunes	Breakfast Roll		Broiled Lamb Chops	Vegetable Hodge Podge; Lyonnaise Potatoes	Jellied Spring Salad	Frosted Peaches and Devil's Delight
5.	Tomato Juice	Omelette	Fruit Juice Cocktail	Fried Bread Ring, Jelly, Grilled Cooked Ham	Green Beans French Style	Pear and Ginger Salad, Summer Dressing	Cream Puffs
6.	Fresh Applesauce	Bacon		Vegetable Plate: Lima Beans, Baked Squash, Silver Onions With Corned Beef Hash		Chiffonade Salad	Whole Peeled Apricots and Chinese Chews
7.	Bananas	Potato Pancakes	Hawaiian Delight	Three-in-One Salad (Fresh Salmon, Green Peas, Diced Beets, Cole Slaw)	Corn and Pepper Pudding		Baked Rhubarb With Strawberries and Spanish Bun
8.	Tangerines	Sausages		Grilled Old English Cheese Sandwich, Rasher of Bacon, Tomato and Olive Canapé	Creamed Raw Cabbage	Hearts of Lettuce, Blackstone Dressing	Green Gage Plums and Hermits
9.	Grapefruit	Boiled Eggs	Tomato Bisque and Saltines	Cold Cuts, Pickled Peach, Cress	Baked Idaho Potatoes	Cucumber and Carrot Strips	Baked Apples and Madeira Cake
10.	Prunes	Bacon		Scrambled Ham and Eggs on Toast Points	Vegetable Plate: Asparagus, Braised Celery, Yellow Squash	Escarole Parisienne, French Dressing	Frosted Raspberries and Scotch Honey Cakes
11.	Grapefruit Juice	Kidney Stew or Sautéed Apple Ring		Corn Puff With Maple Syrup, Grilled Canadian Bacon	Radish Roses, Cress and Escalloped Egg Plant and Tomatoes	Pickled Peach Salad	Mocha Cream Layer Cake
12.	Oranges	Fried Eggs		Swedish Meat Balls, Spaghetti With Tomato Sauce	Wax Beans With Chives	Stuffed Rose Pepper Salad	Fresh Applesauce and Doughnuts
13.	Bananas	Breakfast Patties		Breaded Cutlet, Creole Sauce	Escalloped Potatoes, Fresh Peas and Leeks	Belgian Endive, Spring Dressing	Black Cherries, Orange Sherbet and Cake
14.	Apricots	French Toast, Maple Syrup		Fried Scallops With Lemon	Parisienne Potatoes, Buttered Broccoli	Sweetheart Salad	Fresh Fruit Cup and Valentine Cookies
15.	Oranges	Baked Hash or Jam Rolls or Toast		Roast Beef Sandwich and Dill Pickles	Frosted Succotash	Asparagus and Pimiento Salad	Stewed Frosted Blueberries, Cake
16.	Grapefruit	Scrambled Eggs	Ginger Ale and Grape Juice	Welsh Rabbit, Toast Points, Rasher of Bacon, Tomato Slice		Red Slaw Salad	Fruit Plate (Tangerines, Grapes, Laurel Leaf) and Date Sandwich
17.	Tomato Juice	Creamed Chipped Beef		Griddle Cakes, Maple Syrup, Sausages	Tomato Wedge, Cress, Frenched Green Beans	Hearts of Lettuce, Russian Dressing	Blackberries, Delights
18.	Oranges	Sautéed Calves' Liver	Lime Squash	Vegetable Plate: Kidney Beans, Creamed Spinach, Glazed Carrots, Onions With Walnut Stuffing		Cardinal Salad	Sliced Bananas in Plum Juice, Spun Gold Cake
19.	Tangerines	Bacon		Lamb Chops, Spiced Apricots, Cress	Home Fried Potatoes and White Turnips German Style	Waldorf Salad	Gingerbread With Lemon Sauce
20.	Prunes	Scrambled Eggs	Mushroom Broth	Special Sandwich (Spiced Tongue, Cheese, Pepper Cases Olive, Dill Pickle, Tomato Canapé)	Creamed Corn in (Spiced Tongue, Cheese, Pepper Cases)	Celery Hearts	Stewed Frosted Cherries and Plantation Hermits
21.	Grapefruit and Orange Juice	Broiled Banana	Hot Briar-Cliff Cocktail	Lobster Salad Roll	Peeled Tomato, Potato Chips		Fresh Applesauce With Raisins and Highland Butterscotch Cake
22.	Smyrna Figs	Sausage Cakes		Baked Beans, Brown Bread, Grilled Cooked Ham and Sauerkraut		Romaine, Remoulade Dressing	Fresh Pineapple and Strawberries, Hatchet Cookies
23.	Grapefruit	Boiled Eggs or Baked Beans		Chicken à la Crane en Croustades	Asparagus Tips	Stuffed Beet Salad	Baked Rhubarb and California Fruit Cake
24.	Oranges	Pancakes, Maple Syrup		Broiled Minute Steak	Hashed Brown Potatoes, French Fried Onions	Tomato Salad	Apple Compote, Condés
25.	Bananas	Grilled Bologna	Celery Bisque and Crackers	Open Club Sandwich (Turkey, Bacon, Tomato, Olives, Cucumber, Burr Gherkins)			Fresh Fruit Cup and Brownies
26.	Prunes	Egg Omelette		Browned Fricassée of Meat With Sweet Relish in Lettuce Cup	Swiss Chard, Dumplings	Chicory, Martinique French Dressing	Frosted Peaches and Coconut Iced Cup Cakes
27.	Grapefruit	Bacon		Pigs in Blanket	Vegetable Plate: Fried Egg Plant, Green Beans, Diced Carrots	Brazilian Fruit Salad and Cheese Straws	Orange Cream Cake
28.	Pineapple Juice	Fish Cakes		Shrimp and Almond Omelette, Raw Celery Sauce	Parisienne Potatoes, Spinach Mold	Cucumber and Radish Salad	Bananas With Grape Jell Cubes, Grape Nut Loaf



...with this LAXATIVE FOOD

Kellogg's ALL-BRAN is found on the trays of many modern hospitals. This delicious cereal relieves constipation due to meals low in "bulk."

ALL-BRAN may be served whenever the patient's diet permits "bulk." Tests have shown ALL-BRAN is safe and effective. Within the body, it absorbs at least twice its weight in water, forms a soft mass, gently exercises and sponges out the system. ALL-BRAN also supplies vitamin B and iron.

Pleasing variety may be obtained by serving ALL-BRAN either as a cereal with milk or cream, or cooked in appetizing muffins, breads, etc. Individual packages for each tray save waste. If not used, they may be returned to the pantry.

Have your Kellogg salesman give you the details on our handy Kellogg Menu Planner for hospital dietitians and buyers. Or write to the Institutional Department MH-1, Kellogg Company, Battle Creek, Michigan.



AHEM...
pardon us...

...but you've lost 12 lbs. of Spinach!

At least 12 lbs.

For it's a solemn fact that 12 of every 20 lbs. of spinach you buy is either lost in preparation or shrinks in cooking. Does this sound a bit thick? All right . . . make the little experiment I made and check a bushel of spinach. You'll find, I believe, that it weighs about 20 lbs.

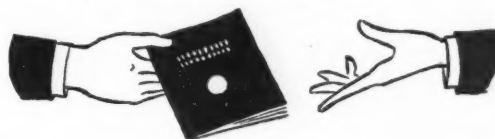


Now, here's where we really begin. The first thing you run smack up against is that old devil waste. I mean the yellow leaves and stalks you have to cut off—which totals a hefty 4½ lbs. you chuck into the garbage pail.

After the messy washing job comes cooking time. And when you lift your spinach out of the pot—lo and behold!—a good 7½ lbs. have vanished in the air! Shrunk! Leaving but 8 lonely lbs. to serve. *Yet you paid for 20!*

What's the answer? We believe it's Birds Eye. For Birds Eye Spinach comes free from all padding—no waste. No yellow leaves to toss away. No stalks to eat up your weight. And, on my honor, *no sand!*

But the most unbelievable part I saved for last. It's *quick-freezing*—a patented process that makes it possible to bring you *garden-fresh* Birds Eye Spinach the entire year 'round! In season or out!



If you're still open to conviction let me send you a book giving weight equivalents of Birds Eye versus the market. Let me prove the hard way—in black and white—how Birds Eye saves waste and points a new way to food profits. A copy will be sent you upon request. Write me at Frosted Foods Corp., 250 Park Avenue, New York, N. Y.

Edwin T. Gibson
EDWIN T. GIBSON
PRESIDENT



NEWS IN REVIEW

Milwaukee Medical Service Program Budgets Income, Pays All Bills

Laying the bogey of state medicine, and at the same time demonstrating that medical, surgical, laboratory and hospital care are available to citizens at a cost within their means, the Milwaukee County Medical Society, Milwaukee, has evolved a system of budgeting the patient's income to cover any expenses entailed during an illness. Known as the Medical Service Program, the plan brings together the patient, the patient's pocketbook and the medical service in a unit directed by the physician and protecting his relationship with the patient.

The operation of the plan is simple. A family physician diagnoses a patient and pronounces an operation necessary. He knows that it will not be possible for the patient to raise the amount of money necessary to meet the cost of this operation, and tells him about Medical Service, suggesting that he go down and talk his problem over.

At the Service, the patient is first referred to the specialist his physician

recommended be called in, who estimates what his charges will be. The Service then estimates the hospital and laboratory fees, and obtains the amount of his fee from the family physician. The budget consultant of the Service then analyzes the patient's income. Upon the facts obtained from the patient and from other sources available to the Service, it is estimated, for example, that Mr. Jones can pay \$200 for services which at regular rates would reach \$300, in monthly installments paid over a ten-month period.

With the approval of the family physician, the specialist and the hospital, the costs are set at \$200, and an arrangement is made whereby Mr. Jones makes his payments to the Service, which pro-rates them to those who have rendered service. The costs of the Service are defrayed through a 10 per cent fee deducted from the funds paid to participants: physicians, hospitals, nurses. In this way the costs of medical care are not raised.

Conference Formed by Group Plan Executives

Group hospitalization executives of New York State have formed a New York Conference on Hospital Service Plans to discuss common problems. The first meeting of the conference was held on November 20 in Albany with C. Rufus Rorem, executive director of the newly formed Committee on Hospital Service, presiding. Those in attendance included Mrs. Corydon Wheat, Geneva; Sherman D. Meech, Rochester; Dr. Arthur S. Moore, Middletown; Frank Van Dyk, New York City; E. R. Evans, Albany; Robert Parnall, Syracuse; Carl Metzger, Buffalo, and Mr. Clark of Elmira.

The entire day was spent in practical discussions of administrative problems. Mr. Van Dyk reported that the new family coverage is proving popular and that the New York plan is now enrolling 1,000 members a day. On November 19, the membership had passed 175,000. Present subscribers are changing over to the family plan and new members are coming in more rapidly than before.

The new plan in Buffalo is practi-

cally ready to launch, according to Mr. Metzger, the director. Mr. Metzger was formerly assistant director of the plan at Rochester. It is expected that the Buffalo plan will give full coverage to dependents as well as subscribers from the beginning.

C. C. Dubuar of the New York department of insurance, who has had direct supervisory control over group hospitalization plans in the state, also attended the meeting. At his request Mr. Van Dyk and Mr. Rorem are to draw up a set of criteria by which the state department can judge when to give approval to new group hospitalization plans.

National Social Hygiene Day

The first National Social Hygiene Day is to be held February 3, according to plans announced by the American Social Hygiene Association. On this day, state and community voluntary organizations interested in the control of social diseases, cooperating with medical and health authorities, will hold meetings all over the United States.

Newark Hospitals Without Light or Power for Hours

Panic was narrowly averted in operating rooms when a fire in the Essex substation of the Public Service Electric and Gas Company plunged a portion of the city of Newark and all of Elizabeth and Irvington, N. J., in total darkness.

For five hours power service in the area supplied by the Essex station was cut off. The Newark Eye and Ear Infirmary did without both heat and light. According to newspaper reports, an incision for an appendectomy had just been made in the abdomen of an eleven-year-old child at Elizabeth General Hospital and Dispensary when the lights went out. A staff electrician hastily set up emergency lighting so the operation could go on.

At St. James Hospital, Newark, a skull fracture operation was in progress. It, too, was concluded through emergency lighting. In another hospital, where the elevator service was disrupted and an emergency patient had to be moved from the first to the fourth floor, he was hoisted on to the shoulders of four interns and carried.

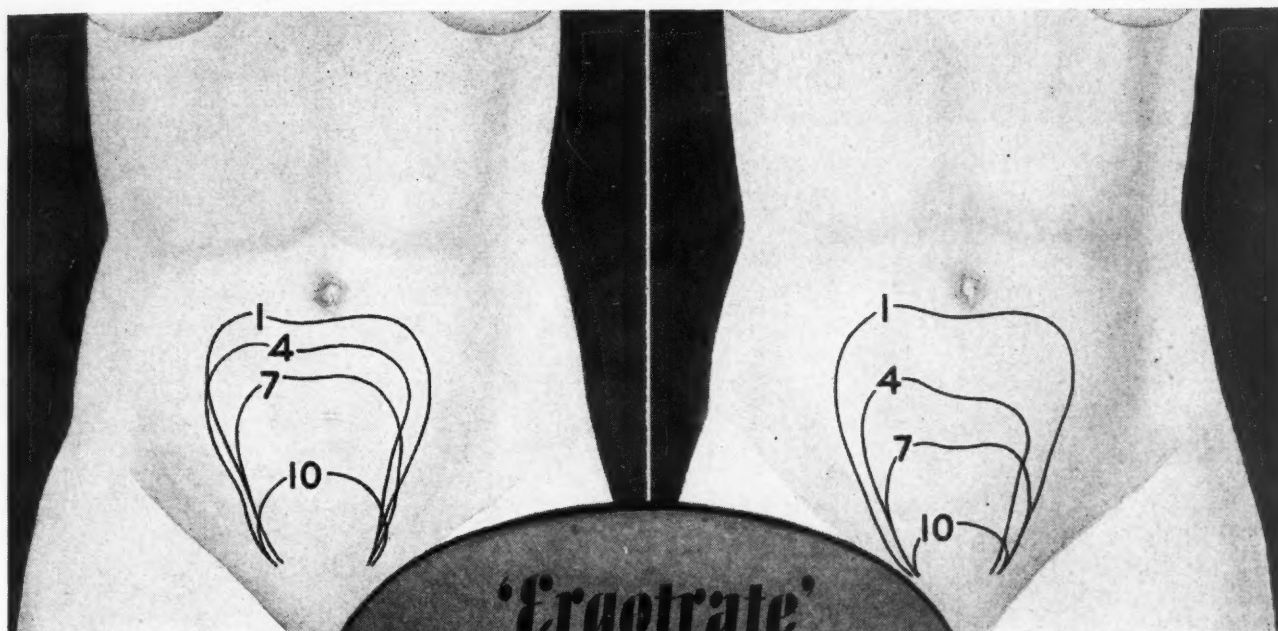
Santa Claus Accompanied by Reindeer at Iowa City

Santa Claus pretty nearly answered every request of the small patients at Children's Hospital of the University of Iowa Hospitals, Iowa City. Early in December they wrote their letters to the jolly saint, asking for "... a doll that shuts its eyes for Christmas," for "... a doll buggy, handkerchief and a box of candy, a little bike and a little dollie and a little scooter for my brother and a play house and a doggie, a new dress and a little new hat and flower vase and flowers."

From all over the state gifts and donations were sent to the hospital. A room was set aside to receive these gifts, and there they were sorted and listed for distribution in the General Hospital, the Children's Hospital and the Convalescent Home. At the Children's Hospital, where the holiday is most anticipated, an electrically lighted Christmas tree was erected in the admitting department, the main lobby and in each ward. Nurses dressed as reindeer pulled Santa Claus' sled.

At the General Hospital electrically lighted trees were placed in each unit and in the front lobby. A large, lighted wreath was hung high on the north side of the tower section, and a decorated tree was placed on the plot of ground before the entrance.

Local groups contributed music and entertainment for patients. Lois B. Corder, director of the school of nursing, headed the committee in charge of the celebration.



*Ordinary uterine
involution—1, 4, 7, and
10 days postpartum*

'Ergotrate' and 'Ergotrate H'

*Involution following
'Ergotrate'—1, 4, 7, and
10 days postpartum*

● The new ergot base which has recently been isolated in pure form supplies all the desirable therapeutic activity of choice medicinal ergot.

Ampoules 'Ergotrate H' (Hydracrylate of a New Ergot Base, Lilly) for parenteral use. The solution is permanent and stable. Intravenous injection is followed immediately by uterine contractions.

Tablets 'Ergotrate' (Maleate of a New Ergot Base, Lilly) for oral use. Absorption from the stomach is rapid and the oxytocic effect well sustained.

These products are indicated to control postpartum hemorrhage and promote uterine involution.

Ampoules 'Ergotrate H' and Tablets 'Ergotrate' are available through the drug trade.

ELI LILLY AND COMPANY

INDIANAPOLIS, INDIANA, U. S. A.

Chicago Plan for Hospital Care Opens Service With Thirty-Nine Hospitals

Thirty-nine hospitals in the Chicago area have agreed to participate in that city's Plan for Hospital Care, being presented to the public after two years of preliminary work and study. Like the majority of low cost plans, the service offers twenty-one days of service to subscribers at an annual fee of \$9.60.

In addition to the subscriber, the plan provides for the care of dependents at an additional charge of \$4.20 for the first dependent and a second fee of \$4.20 for all other dependents. Dependents, under the plan, are husband, wife and unmarried children under nineteen years of age.

First subscribers to the plan were members of Rand McNally and Company, second were from the Chicago offices of the National Broadcasting Company. Members of the board of directors of the plan include Taylor Strawn, trustee of Grant Hospital and president of the plan; J. Dewey Lutes, superintendent of Ravenswood Hospital and vice president of the plan; Charles H. Schweppe, president of St. Luke's Hospital and treasurer of the plan; the Rev. John W. Barrett, direc-

tor of Catholic hospitals in the Archdiocese of Chicago and secretary of the plan; Dr. Arthur C. Bachmeyer, superintendent of the University of Chicago Clinics, and Dr. Irving S. Cutter, dean of Northwestern University Medical School and superintendent of Passavant Hospital.

Participating hospitals are Alexian Brothers, American, Augustana, Columbus, Englewood, Evangelical, Garfield Park, Grant, Henrotin, Holy Cross, Home for Destitute Crippled Children, St. Anthony de Padua, Jackson Park, Lake View, Lutheran Deaconess, Lutheran Memorial, Mercy, Michael Reese, Mother Cabrini Memorial, Mount Sinai, Norwegian-American, Passavant Memorial, Presbyterian, Provident, Ravenswood, St. Anne's, St. Bernard's, St. Elizabeth's, St. Joseph's, St. Luke's, St. Mary of Nazareth, University of Chicago Clinics, Wesley Memorial, and Woodlawn, in Chicago proper; Evanston Hospital, Evanston; Oak Park and West Suburban Hospitals, Oak Park; Little Company of Mary Hospital, Evergreen Park, and St. Francis' Hospital, Blue Island.

Outline Plans for Paris Meeting of I. H. C. in July

The 1937 meeting of the International Hospital Congress will convene in Paris, France, July 6 to 11, in the "Arts and Professions" building, located close to the grounds of the International Exhibition of Arts and Technics in Modern Life. Albert Chenevier, the secretary of the public assistance administration at Paris, is to be honorary secretary of the congress.

National planning of hospital services will be discussed by French, German, Italian and English administrators. Among the other subjects scheduled are hospital visiting, the right of the hospital in regard to case histories of patients, general nursing problems, hospital finance and publicity and the hospitalization of mental cases.

Arrangements are being made for several special tours. During the week preceding the congress, one is scheduled for the Lyons district, to include the hospitals of Lyons, the sanatoriums of the Alps and the Hospices of Beaune. An alternative trip in another part of France will probably be arranged.

It has also been suggested that a study tour of British hospitals might be arranged for American delegates

on the way to and from the congress. Dr. Malcolm T. MacEachern, American College of Surgeons, is asking that those intending to attend the congress get in touch with him so that it will be possible to discover the demand for such a tour.

During the session of the congress, afternoons will be devoted to two types of tours, one of a technical nature, to hospitals, including the Cancer Hospital at Villejuif, the other of a sight-seeing nature, mainly for the benefit of persons accompanying delegates, who are not themselves hospital workers.

It has not yet been possible to fix the fee for attending the congress because of the variable state of the exchange, but a figure of 100 francs has been suggested. This would entitle visitors to considerable concession in fares on all French railways during a period of three months, and probably to free entrance to the Exhibition.

No Fees for No Parking

The exemption of hospitals from the payment of fees to the city for the use of "No Parking" signs was finally obtained in Columbus City, Ohio, through the efforts of the Ohio Hospital Association.

Summarize Aid to N. Y. C. Hospitals

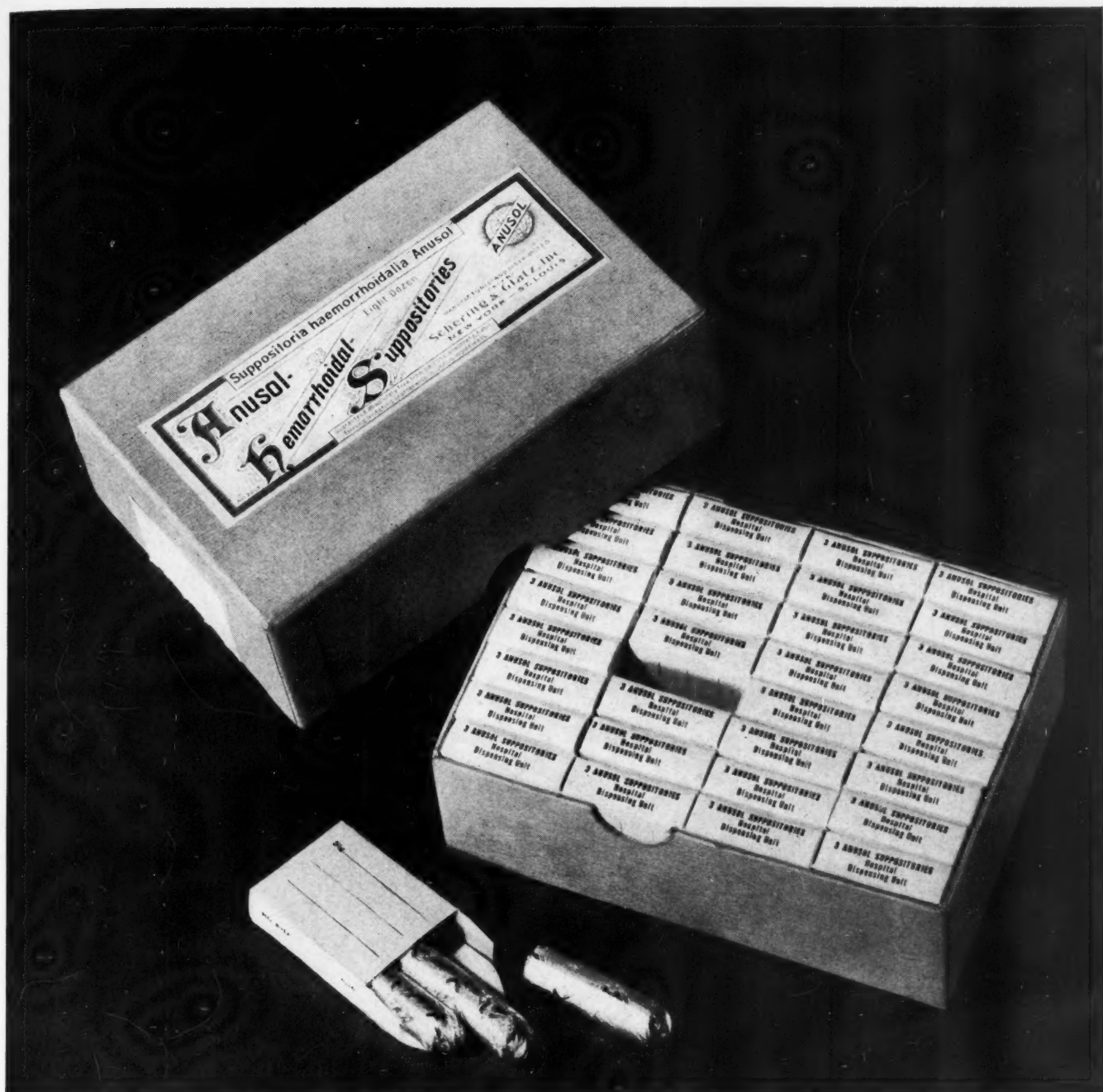
Through the depression years, the department of hospitals of New York City received \$16,000,000 on a grant and loan basis from the federal government. Dr. S. S. Goldwater, commissioner of hospitals, in an address to the visiting committee of the State Charities Aid Association, summarized the contributions, pointing out that 153 alteration and renovation projects were carried out through these funds at an estimated cost of \$2,570,000, and that at the present time 190 projects are under way at an estimated cost of \$3,230,000. In addition to construction projects, the department's normal force of 20,000 professional and non-professional volunteer and paid workers has been augmented by about 3,000 persons assigned by the WPA.

To Train the Specialist

In step with the new movement to eliminate incompletely trained, unqualified specialists from practicing as specialists, the college of medicine of Wayne University, Detroit, is establishing adequate educational standards and registration requirements. A training program leading to the M.S. degree in medicine for medical school graduates who wish to specialize in some branch of the basic medical sciences, as anatomy, bacteriology, physiology, or in one of the clinical specialties, as general surgery, internal medicine, neurology, obstetrics and gynecology, has been inaugurated by the college. These courses are being offered to the full-time staff members of various Detroit hospitals, and tuition in this postgraduate work is being waived by the board of education. Short courses for the general practitioner, designed to aid him in professional improvement, will be offered co-operatively by the schools of medicine of Wayne University and the University of Michigan and the Michigan State Medical Society.

Group Plan Takes Shape

Group hospitalization, it is anticipated, will be formally presented to residents of Allegheny County, Pennsylvania, within ninety days. The plans for the seventy-two cents a month service are now being submitted to the boards of twenty-five voluntary hospitals and to medical organizations for approval. Similar to New York's plan, though less expensive, the Allegheny service allows the subscriber the usual twenty-one days in semi-private quarters in the hospital of his choice and is based on memberships in groups of ten. H. Lee Mason, Jr., chairman of the executive committee of the Allegheny General Hospital, Pittsburgh, is chairman of the committee organizing the service.



NOW... 96 INSTEAD OF 72

INCREASED demand by hospitals enables us now to supply to hospitals and institutions eight dozen Anusol Suppositories instead of six dozen as heretofore. The price remains the same: \$4.00 net.

A special Hospital Package is designed for convenience in dispensing. Each dispensing unit contains three Anusol Suppositories in a carton, with space for directions.

Shall we send you a special price list of all Schering & Glatz products available at special low prices to hospitals?

This special Hospital Package can be supplied only to hospitals and institutions on orders sent to us direct, as this low price permits no discounts or commissions. And truly this low price brings Anusol Suppositories within the budget of all hospitals.

SCHERING & GLATZ, INC., 113 West 18th Street, New York City

NEW BUILDING PROJECTS

AGNEW, CALIF.—A program to relieve the crowded conditions at Agnew State Hospital will soon go into effect with the erection of additions to cost \$300,000.

LEWES, DEL.—Funds are now being raised for the construction of a three-story addition at Beebe Hospital of Sussex County to be erected at a cost of \$70,000. Plans call for a fireproof building with a basement kitchen, patients' rooms on the first floor, nurses' rooms on the second and an operating room on the third.

ST. PETERSBURG, FLA.—Plans have been completed, though a construction date has not been set, for a new St. Anthony's Hospital to be erected at an approximate cost of \$225,000. Located just south of the present hospital, the building will be a restricted "U" shape, with the two wings three stories high and the main section, four stories. The flat roofs of the wings will be utilized for open sun porches, while the roof of the main section will be finished with a high, glass enclosed loggia and promenades. Seventy-five patients' rooms will be added to the capacity of the institution when the new building is completed, bringing it to a total of 150. Administration offices will be in the new building, the old being remodeled into patients' rooms. Rooms in the old building will be made available at more moderate rates. The architect is Gerald A. Barry of Chicago.

BALTIMORE.—The three-story, \$185,000 addition to Franklin Square Hospital was completed on December 11 and opened to the medical profession for inspection the following day. The building has a central heating unit, sixty rooms, four wards, a nursery, laundry and kitchen, and raises the capacity of the hospital to 160 beds.

PATCHOQUE, N. Y.—The John Van Brunt Roe Hospital moved a step toward becoming an actual hospital when tentative plans for its construction were approved by the village board. The plans provide for a four-story institution with a minimum capacity of thirty-three beds and twelve bassinets. The money for this hospital came to the city under the terms of the will of Nettie C. Roe, who specified an amount, thought to be about \$250,000, to go to a nephew she had not seen for years, with a codicil to the effect that if he could not be located the sum should be given to the village to be used in constructing a hospital. The specified time for the search has since elapsed and the money has been given to the village.

COLUMBUS, OHIO.—Passage of a \$660,000 bond issue has made certain

an addition to Franklin County Tuberculosis Hospital, which will increase its capacity from 180 to 380 patients. The new addition will be erected south of the children's pavilion, its four-story main building with three-story wings so placed that the full benefit of the sun may be obtained. Special glass will be used throughout the building so that the sun's rays will not be filtered. The main building will house administrative offices, laboratories and operating rooms, while the wings will each house one hundred patients.

NORRISTOWN, PA.—A ten-year-old replacement program is about to be realized at Montgomery Hospital. The plans for the proposed six-story, \$450,000 building have been drawn by Mallinger Company, Philadelphia. Features of the hospital's new home will be ample out-patient clinics; a segregated isolation department; a children's department, which though located on the first floor will be operated as a unit apart from the rest of the hospital; a floor given over to the maternity department, with two nurseries, one for isolation purposes, and a floor of private rooms, with large sun rooms located at each end.

WAYNESBURG, PA.—A final drive for \$25,000 provided funds to erect the third floor of the new Greene County Memorial Hospital. Plans were originally drawn for the building in 1928 but construction was not begun until last year.

DALLAS, TEX.—Construction of a \$75,000 charity clinic and children's hospital will be begun this month by St. Paul's Hospital. Harmonizing with the present hospital building in color, the five-story structure will be built of red brick and reinforced concrete. The new hospital will have consulting rooms, wards and offices, and its clinical apparatus will be of the most recent design.

HOUSTON, TEX.—Though to all outward appearances the new hospital being erected by the Sisters of Charity who operate St. Joseph's Infirmary will be one building, the structural appearance of the hospital will be deceptive, for it is to be operated as two distinct hospitals, one a fifty-bed children's hospital, the other a seventy-five-bed maternity hospital. To be erected and equipped at a cost of \$750,000, the building will be five stories high, of reinforced concrete, with terrazzo floors and a lobby done in marble.

SALT LAKE CITY, UTAH.—Plans have been approved for a state tuberculosis sanatorium to be erected at a cost of \$750,000.

Plan Movable Inside Walls for Australian Hospital

Movable walls will be an outstanding feature of the new Royal Melbourne Hospital, Parkville, Australia. To be located on a block of land that for years has been known as the pig market site, the \$4,000,000 hospital and medical center will be just one mile from Melbourne proper.

The building is to be constructed of steel and concrete, with the outside walls, columns and floors the only permanent fixtures. Almost all of the inside walls and partitions are to be movable. Plate glass and glass brick will be used wherever it is necessary to have a solid wall.

On none of the ten floors will there be a dark corner or a gloomy passage. In all, the hospital will have fifteen operating theaters, eight of which will be grouped on the top floor. Of the 700 beds, 100 will be for the care of intermediate and private patients.

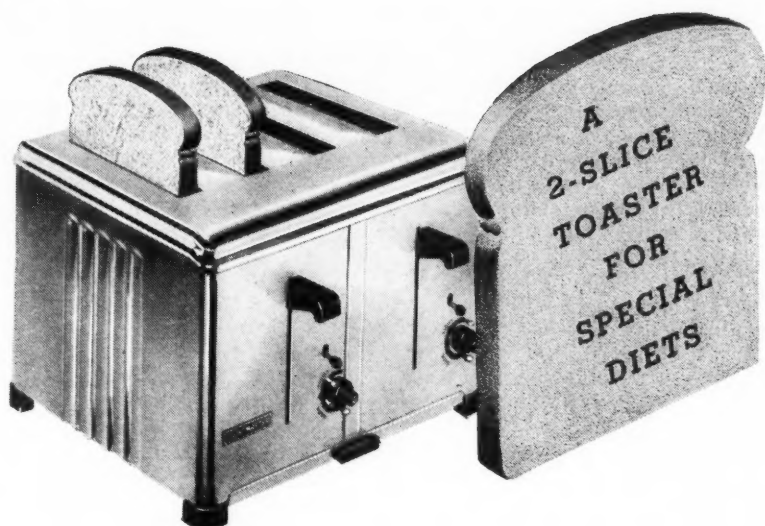
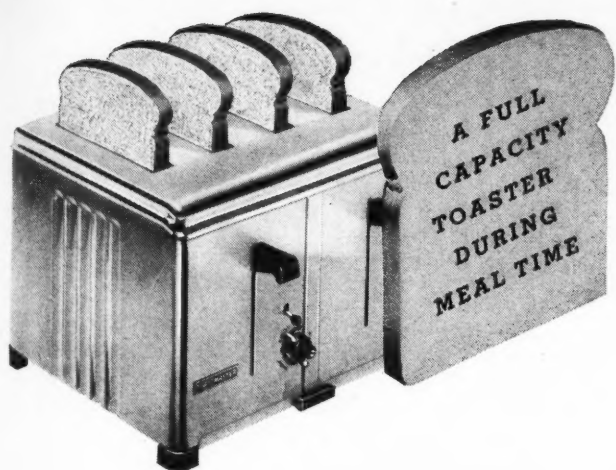
Tennis courts, a squash court, a croquet lawn, a swimming pool and concert and lecture halls are planned for the nurses. Training schools for both nurses and dietitians will be conducted by the hospital. It is expected that three years will be necessary to construct the building.

Largest Hospital for Stockholm

Stockholm, Sweden, has announced that it is about to build the largest hospital in the world. It will accommodate 1,542 bed patients and will have 14 polyclinics. Construction costs are estimated at 24,582,000 kronor (about \$6,231,537) and equipment costs at 4,000,000 kronor (about \$1,014,000). In order that the architect's plans will be fully applicable, full size model wards are being constructed as well as a miniature of the entire hospital as it will appear when completed. The hospital is to be built in sections, as it is needed.

Designed for War

The threat of war hangs heavily over Europe today, how heavily can be realized in the plans for the new Westminster Hospital, London, England. This £850,000 hospital is designed to be invulnerable in case of a gas attack on the city. Access to all departments will be through a covered road, 24 feet wide, that can be converted into a gas lock in emergencies by double doors at each end. In case of an air raid, persons entering the hospital will be cleansed of gas in this entry. Splinterproof glass will be used throughout the building. The hospital will also have air conditioning in many departments.



You pay no bills for wasted fuel when New **TOASTMASTER** Toaster makes your toast! It uses current only in slots that are actually working . . . it shuts off the instant the toast is crisp and delicious. Every slice costs less—yet every slice is exactly as your patients like it, because the Flexible Timer can never make a mistake! May we send you complete facts?

ONE OF THE FAMOUS TOASTMASTER PRODUCTS
made by

McGRAW ELECTRIC COMPANY
TOASTMASTER PRODUCTS DIVISION

Dept. 1, 231 North Second Street, Minneapolis



Made in 3, 4 and 6 slice models and a heavy duty 2 slice model for diet kitchens . . . small capacity in a construction that will give years of service.

NEW TOASTMASTER Toaster

MAKES MOST OF THE WORLD'S TOAST

American College of Surgeons to Hold First Sectional Meeting at Atlanta, Ga.

The first sectional meeting of the American College of Surgeons will be held in Atlanta, Ga., February 3 to 5, for the states of Georgia, Florida, North and South Carolina, Tennessee, Alabama, Mississippi and Louisiana.

The opening session of the conference will be turned over to the problems of the small hospital in a panel under the leadership of Dr. William S. Rankin, director of the Duke Endowment. Among those participating will be Dr. J. F. Highsmith, Highsmith Hospital, Fayetteville, N. C., who will discuss the medical staff organization and conferences in the small hospital; Dr. L. L. Lippincott, superintendent, Vicksburg Sanitarium and Crawford Street Hospital, Vicksburg, Miss., whose subject will be clinical laboratory and x-ray services, and Agnes Coleman, Emory University Hospital, Emory University, Ga., who will dissect the problems of food service.

Hospital standardization in retrospect in which Dr. George Crile, director, Cleveland Clinic Foundation, Cleveland, reviews the past twenty years, will open the afternoon program. Doctor Rankin is scheduled to discuss the control of surgery; Dr. Charles L. Scudder, Massachusetts General Hospital, Boston, the supervision of fracture work in a general

hospital; Dr. Frank E. Adair, executive officer, Memorial Hospital, New York City, the cancer patient in the general hospital, and Dr. James T. Nix, Louisiana State University Medical Center, will close the session with his talk on following up and studying end results.

A discussion of everyday hospital problems—administrative, professional and economic, will be led by Robert Jolly, superintendent, Memorial Hospital, Houston, Tex., at eight o'clock that evening. On the following day the program will be opened by a similar discussion also under the leadership of Mr. Jolly. J. B. Franklin, superintendent, Grady Hospital, Atlanta, Ga., is scheduled to open the discussion revolving about administrative problems.

The other district meetings are to be held in Edmonton, Alta., March 24 and 25, for Alberta, Saskatchewan, and Manitoba; in Seattle, March 31 and April 1 and 2, for Washington, Oregon, Idaho, Montana and British Columbia, and in Denver, April 7 to 9, for Colorado, Utah, Wyoming, Nebraska, Kansas, Oklahoma, New Mexico, Arizona and Western Texas. A fifth meeting is contemplated for Halifax, N. S., for the maritime provinces of Canada, but arrangements are not yet completed.

Conference Listens to Medical Social Workers

Medical social workers were given their inning by the Hospital Conference of the City of New York, when the North Atlantic District of the American Association of Medical Social Workers met with the hospital conference at Mount Sinai Hospital, New York City. Approximately 250 persons attended this meeting, the second to which the Conference has invited an allied professional group for participation.

The lack of rapport between social case workers and physicians was laid to the fact that a particular form of technical phraseology has grown up among the social workers which lacks significance to the physician. Dr. S. S. Goldwater, commissioner of hospitals, suggested that an evaluation of social case problems in terms of diagnosis and therapy might be the common ground upon which social worker and physician could discuss problems with better understanding.

The function of the medical social worker in the hospital was discussed

by Marjorie Nichols, chairman of the North Atlantic District, whose talk was made pointed by the liberal use of illustrations of service. Dr. Haven Emerson, director of the hospital survey for New York, commented upon the inadequate number of competently trained social workers, and the difficulties which exist because the social service department is not integrated into the scheme of the hospital.

It was pointed out, in the general discussion under the leadership of Dr. E. M. Bluestone, superintendent, Montefiore Hospital for Chronic Diseases, that it would be desirable if the budget of the social service department could be included in the general hospital budget. A stricter definition of medical social work than is at present in force was also advised.

A. H. A. Chooses Atlantic City

Atlantic City, N. J., has been selected for the annual convention of the American Hospital Association, to meet in 1937 during the week of September 13.

Connecticut Association Meets

The important subject of welfare departments in hospitals was discussed by William J. Ryan, superintendent of welfare, Hartford, at a recent meeting of the Connecticut Hospital Association held at Municipal Hospital, Hartford. Also on the program was a discussion of worth-while hospital statistics by John H. Watkins of the department of public health, Yale University. New trends in nursing were presented in a talk on the administration of the revised curriculum for nursing schools by Dean Effie J. Taylor of the School of Nursing, Yale University. A discussion of Dean Taylor's address was led by Augusta Patton, chairman of the educational section of the Connecticut State Nurses' Association. Following an inspection of Municipal Hospital, Joseph W. Hinsley, assistant business manager of that institution conducted a round table.

N. J. Dietitians Reelect President

Asta Low Packard was reelected president of the New Jersey State Dietetic Association at its fourth annual meeting held recently at the New Jersey College for Women, New Brunswick. Lillian Park, Essex County Hospital, Cedargrove, was elected vice president of the association; Isabelle Stewart, Essex Mountain Sanatorium, Verona, was made secretary, and Mary Murphy, Seton Hall College, South Orange, treasurer. Among the speakers at the sessions were Grace MacLeod, professor of nutrition, and Isabel Stewart, professor of nursing education at Teachers College, Columbia University.

Service for Western New York

January 1 saw the inauguration of the Hospital Service Corporation of Western New York with headquarters at Buffalo. The plan offers the usual twenty-one days of hospitalization and has been approved by the Medical Society of the County of Erie. There are eight participating hospitals in Buffalo, one in Lackawanna and two in Niagara Falls. Carl M. Mezger is executive director.

Coming Meetings

Western Hospital Association.
Next meeting, Los Angeles, April 12-16.
Ohio Hospital Association.
Next meeting, Columbus, April 13-15.
Hospital Association of Pennsylvania.
Next meeting, Buck Hill Falls, June 2-4.
Mid-West Hospital Association.
Next meeting, Colorado Springs, Colo., June 10-11.
Minnesota Hospital Association.
Next meeting, Rochester, May 13-15.
International Hospital Association.
Next meeting, Paris, July 6-10.



M. BURNEICE LARSON
DIRECTOR.

*... a job you'd love ... where you'd smile and whistle
and sing and draw great, deep, unbelieving breaths.*

You've *lived* in a job like that, or you've dreamed of having a job like that, we *know!* and if you haven't one just like it *now* . . . it is just around the corner.

You can have it if you'll make up your mind and will that you'd be worth it, that it would be worth all that you could ever put into it.

All over America there are hospitals and schools and public and private institutions and even individuals who *have* jobs for you that you'd love where you'd smile and whistle and sing and draw great, deep, unbelieving breaths.

If you haven't a job like that, and if you deserve it, we'll help you to find it.

If you have jobs *to give*, and if you want people to fill them who are fine and smart and able and eager, we'll find *those* workers *for you*.

Around the corner, is *the job* you'd love, and smile over, and lick around the corner is *the employee* who'd give you great peace of mind.

Ask us for *people* like that; ask us for *jobs* like that; we probably have them listed now; the right jobs for real people; the right people for your fine jobs. These tasks are our great business.

The MEDICAL BUREAU

55 E. Washington St.

The top floor of the tower of the Pittsfield Building
CHICAGO, ILLINOIS

NAMES IN THE NEWS...

Doctor Sexton Dies

Dr. Lewis Albert Sexton, superintendent emeritus of Hartford Hospital, Hartford, Conn., died at his home on December 3 at the age of sixty. Doctor Sexton was formerly president of the American Hospital Association,



of the New England Hospital Association and of the Connecticut Hospital Association. His first hospital appointment, after a residency at the Willard Parker Hospital, New York City, was the assistant superintendency at Johns Hopkins Hospital, Baltimore, where he remained from 1914 to 1917. In 1917 he was named superintendent of Hartford Hospital, a position he filled with honor until September of this year, when, upon his retirement, he was made superintendent emeritus.

DR. J. HARVEY JENNETT, superintendent of Kansas City General Hospital, Kansas City, Mo., for four years, and assistant superintendent of the institution for five years previous to his appointment as head, has announced his resignation in order that he may practice privately. DR. PETER F. DEMARIA, assistant superintendent, has been appointed to succeed Doctor Jennett, and DR. DRURY R. THORN has been named assistant superintendent.

DR. SIMON B. KELLEHER, superintendent of Cambridge Tuberculosis Hospital, Cambridge, Mass., has resigned to be city medical inspector and to issue working certificates. He will be succeeded at the hospital as superintendent by MARGARET CONLIN, the present matron.

DR. RICHARD THAYER has been appointed superintendent of Detention Hospital, Beloit, Wis.

JESSIE F. M. HARROD, superintendent of Montclair Community Hospital, Montclair, N. J., died at the age of 54. Miss Harrod had been in ill health since last spring, but continued in charge of the institution until just prior to her death.

DR. WILLIAM H. PRITCHARD, superintendent of Columbus State Hospital,

Columbus, Ohio, for more than twenty years, died at the hospital following a heart attack. Doctor Pritchard's death occurred just two days short of his seventieth birthday. DR. ISABEL A. BRADLEY, assistant superintendent, will be acting superintendent of the institution pending a permanent appointment to the position.

DR. J. C. O'NEIL has been named acting superintendent of the Vermont State Hospital, Waterbury, Vt., where he succeeds the late DR. EUGENE A. STANLEY.

H. K. FORD, superintendent of Little Rock City Hospital, Little Rock, Ark., has resigned from that position to accept the office of city sewer manager, in which capacity he will be in charge of collections, operation and maintenance of the new sewer improvement program.

E. L. WOODSON, business man of Madera, Calif., has been appointed superintendent of Ahwahnee Sanatorium, Ahwahnee, Calif., to succeed MRS. LOLA A. CEASE.

INEZ B. SMITH, superintendent of Milford Hospital, Milford, Conn., has announced her retirement from that position because of ill health. EDITH ODDY has been named acting superintendent.

ELIZABETH MARTIN is the new superintendent of Children's Mercy Hospital, Kansas City, Mo., where she assumed her duties on December 7.

FRANCES T. ROBBINS has been named superintendent of nurses at Olive View Sanatorium, Olive View, Calif., to succeed MRS. GERTRUDE E. PERSHING.

MOTHER ANN VALENCIA, superintendent of St. Francis Hospital, Hartford, Conn., since its founding in 1897, died recently.

ALEXANDER HODGEMAN, one time superintendent of Hoffman Memorial Hospital, San Diego, Calif., has been appointed superintendent of Seaside Hospital, Long Beach, Calif., where he succeeds MRS. LAURA PRALL SETILSON.

NAOMI WEBER has been named to succeed MRS. R. G. CANADA as superintendent of Good Samaritan Hospital, Galion, Ohio.

FRED W. HEFFINGER, superintendent, Mercer Hospital, Trenton, was elected executive secretary of the New Jersey Hospital Association, succeeding JOHN G. MARTIN.

E. WEBB is the new superintendent of Sapulpa City Hospital, Sapulpa, Okla.

VERA A. ALLAN, superintendent of Lynn Hospital, Lynn, Mass., resigned on January 1 to take a much needed

rest. She is being succeeded by DAN TRANER, superintendent of Swedish American Hospital, Rockford, Ill. Miss Allan has been Lynn's superintendent for over seventeen years.

CECELIA MEISTER has been appointed superintendent of Bishop Clarkson Memorial Hospital, Omaha, Neb.

DR. G. OTIS WHITECOTTON, formerly assistant to DR. B. W. BLACK, superintendent of Alameda County Hospital, Oakland, Calif., has been named superintendent of Stanford University Hospitals, San Francisco.

EDITH STOLPE has been appointed dietitian at Berkeley General Hospital, Berkeley, Calif.

DR. W. E. PARK, superintendent, Veterans Administration Facility, Pittsburgh, has been appointed superintendent of the Veterans Administration Facility at Rutland Heights, Mass., where he succeeds DR. R. L. COOK. Doctor Cook has been named head of the Facility at Tupper Lake, N. Y.

DR. IMAS P. RICE, who was superintendent of Kane County Spring Brook Sanitarium, Aurora, Ill., from its opening in 1921 until his death last April, was honored when a bronze plaque was dedicated to his memory on December 6.

DR. RAYMOND W. WAGGONER, associate professor of neurology, University of Michigan school of medicine, has been appointed director of State Psychopathic Hospital, Ann Arbor, Mich., to succeed the late DR. ALBERT M. BARRETT.

False A. C. S. Representative

Under the pretext of being a representative of the American College of Surgeons, a man calling himself Doctor Hoban gained entrance to the doctors' locker room at St. Vincent's Hospital, Worcester, Mass., with it is believed, the express purpose in mind of robbing the physicians' lockers. The Sister in the surgery, whose suspicions were aroused by the fact that the hospital had not been notified by the College to expect a representative, and by the man's abrupt manner, called him from the locker room, where he was ostensibly donning a gown and mask to witness an operation, and requested that he meet the hospital superintendent. While she attempted to locate the superintendent by phone, the man disappeared from the hospital. Dr. Malcolm T. MacEachern, notified by the hospital of the visitor, stated that the College does not have a representative doing survey work in the East at the present time, and that the man did not represent the American College of Surgeons. He also added that before any representative of the College visits a hospital, due notice of the visit is sent the superintendent.

Now is the time to raise money

Money for building, modernization, or to "balance the budget"

● The recently published statistics for 1936 teem with eloquent evidence of better times—increased production and consumption, widespread reemployment, higher wages and incomes, larger dividends, etc.—improving the condition of all classes throughout the country.

At the same time it is revealed that occupancy of voluntary hospitals has advanced considerably, involving the hospitals in higher operating costs.

The prospects of successful campaigns for funds for hospitals have been greatly enhanced under these circumstances. But maximum results are only assured when the best methods are most expertly applied.

The associates of this firm have all been carefully chosen, thoroughly trained in its principles and methods, and each has an established record of high performance—all with the purpose to maintain the firm's position of commanding leadership in its field.

A "WARD, WELLS & DRESHMAN" director is a director with a record of achievement and proven ability.

KNOW A FIRM BY ITS RECORD

Ward, Wells & Dreshman

Fifty-first Floor - R. C. A. Building

ROCKEFELLER CENTER

NEW YORK CITY

STERILE! THE WATCHWORD OF EVERY HOSPITAL

Super cleanliness, the essential of every hospital, is attained when equipment is *easily* cleansed. Trays made of Boltalite have a smooth dense surface which will not harbor germs. All edges and corners are rounded to add strength and facilitate cleaning. These trays are solid Boltalite, which means that there is no surface finish to chip, crack, peel or mar. The rich mahogany color is an integral part of the tray and cannot change, even though trays



BOLTALITE
TRAYS



are sent through the dish washer at high temperature many times. Ask your equipment dealer to tell you more about these quiet, trouble-proof, sanitary trays, or use the handy coupon below.

THE BOLTA RUBBER CO., INC.
LAWRENCE MASSACHUSETTS

Gentlemen: Kindly send me information about the complete line of Boltalite products.

Name.....
Position.....
Hospital.....
City..... State.....

READER OPINION

A. H. A. History

Sirs:

In your article on the "Rosenwald Grant" on page 38 of the December issue I wish to correct your statement regarding the date of the establishment of permanent headquarters and the employment of a full time executive secretary for the American Hospital Association.

The full time executive secretary was employed, permanent headquarters were established and the board of trustees was organized in 1916 at Philadelphia.

History is so perverted by inaccuracy that I believe you should get these dates straight in your columns.

WILLIAM H. WALSH, M.D.

Chicago.

The 1935 Transactions of the American Hospital Association support Doctor Walsh's contention, at least in part. For the Cleveland convention (1917) Doctor Walsh is listed as executive secretary—the first time that this title appears. His address, however, is given as Philadelphia that year and Washington, D. C., the next year. In 1919, Howell Wright is listed as executive secretary and the address is given as Cleveland. By the time of the 1920 convention, Dr. A. R. Warner had been appointed executive secretary and the headquarters moved to Chicago, where they have ever since remained.—Ed.

Hell Year

Sirs:

Do you remember that week just before being initiated into your fraternity? "Hell Week" it was called—seven days of utter domination by upperclassmen, innumerable menial tasks, harrowing experiences, untold humiliations, immoderate restrictions—and then the glorious reward, initiation into the fraternity.

So every intern serves a period which might well be termed "Hell Year." The young man, with a brand new M.D., a buoyant heart and a slim purse, apprentices himself to a hospital to fulfill those last requirements before entering medical practice.

There are only two interpretations of Hell Year: either the M.D. degree is not a symbol of knowledge, competence and training, and its holder is not a man worthy of man's wages, humane hours and normal intercourse with his fellows; or the hospitals have built up a monstrous myth as to the beneficial effect of delaying the doctor's maturity. . . .

The intern is a subordinate without income, separated from his family, surrounded day and night by sick people, dying people, dead people, disease and unhappiness, all resulting in a terrible strain from which there is no relief. He is subjected to the monotony of constant serving and the irksome clerical duties only interns fall heir to! He is made the innocent victim of petty organizational squabbles and the butt of irritable doctors and inefficient nurses. Usually he is housed in drab living quarters and served unappetizing food. All this for that wonderful day when he will be taken into the "inner circle" of full-fledged medical men. . . .

It should not be so difficult to remedy the situation, in part, at least. Surely, concerted effort can be made by hospital organizations and medical associations to provide the intern with pleasant quarters, well prepared and attractively served food, a leisure schedule as well as a work schedule, a program of duties which will preserve his dignified status as M.D. rather than make him a drudge, an adequate income, and the possibility of a happy and normal family life during this trying period of internship.

JANE WARD

161 Brighton Road,
Columbus, Ohio.

To Advise on Office Procedures

Any hospital wishing to develop a stores system or to set up accounting or other office procedures may have the advantage of expert assistance and advice simply by being a member of the Hospital Association of Pennsylvania. This organization, in keeping with its policy of service, is now offering an office procedures service to members. S. Hawley Armstrong, for nine years the senior institutional disbursement accountant of the state department of welfare, has been placed in charge, and will operate from headquarters to be established at Harrisburg.

Celebrates Silver Anniversary

In observance of its silver anniversary, friends of the Lutheran Hospital of Manhattan staged a gala dinner at the Hotel Astor, New York City. In conjunction with the event efforts are being made to reduce the hospital's indebtedness \$25,000. Among the 500 participating were Dr. S. S. Goldwater, commissioner of hospitals, and Dr. John L. Rice, commissioner of health, New York City. Charles O. Pauly, managing director of Lutheran Hospital, was in charge of the arrangements.

A. P. H. A. Issues Bulletin

The first issue of the Bulletin of the American Protestant Hospital Association appeared in December. A four-page pamphlet, 8½ by 11 inches in size, the issue carries a statement of purpose by Arthur M. Calvin, president of the association and executive manager of the Midway Hospital and Mounds Park Hospital, St. Paul, Minn.; a list of the officers and committee members; a report of the 1936 convention, and a message from the publication committee.

Low Maternal Mortality Rate

At the recent meeting of the Evanston Hospital Association it was reported that the maternal mortality of that institution in the last eight years was 0.21 per cent. Dr. W. C. Danforth, head of the department of obstetrics, declared that it is viciously untrue that the hospital is a dangerous place for maternity cases. On the contrary, he declared, the hospital which is staffed by adequately trained specialists in obstetrics is the safest place in the world for a delivery.

BEQUESTS AND GIFTS

MORGAN HILL, CALIF.—The nucleus of a municipal hospital fund was left to Morgan Hill by the late Frank W. Barber, a rancher, who specified in his will that \$15,000 should go to the town for that purpose.

LOUISIANA.—The total donations of the late Mrs. Leona Soniat, widow of an Iberville Parish planter, to Mercy Hospital, New Orleans, were brought to approximately \$300,000, with a final \$50,000 bequest contained in her will. The gift is to be a memorial to her husband.

NEW YORK CITY.—The residuary estate of the late Mary Gardiner Thompson is to be divided between six institutions and societies, including Presbyterian Hospital, New York Hospital, the Children's Aid Society and the New York Association for Improving the Condition of the Poor, each of which will receive \$2,201,491.

CINCINNATI, OHIO.—Children's Hospital received an outright gift of \$250,000 from the estate of the late Mrs. Annie L. Dana.

BRYN MAWR, PA.—At the close of the Devon Horse Show and County Fair, that institution presented Bryn Mawr Hospital with \$42,000.

PHILADELPHIA.—The gastro-intestinal clinic of the Graduate Hospital of the University of Pennsylvania is to be the recipient of the bulk of an estate estimated at \$200,000. The will of the late Frances T. Kinsey has established the Kinsey-Thomas Foundation for the Study and Treatment of Diseases of the Digestive System, in memory of two sisters and a brother-in-law. The fund is to be used under the direction of Dr. Thomas Grier Miller, and if he severs his connection with the hospital the income is to be used for any similar activities the doctor wishes.

NEW YORK CITY.—Flower Hospital is to receive \$50,000 through the will of the late Elias C. Benedict and \$5,000 through the will of the late George Leask. . . . The late Charles L. Hoffman left \$3,942 to the Hospital for Joint Diseases. . . . Montefiore Hospital for Chronic Diseases and Mount Sinai Hospital will each receive \$8,115 from the estate of Henry Ollesheimer and \$2,500 from the estate of Jacob W. Gutman.

STATEN ISLAND, N. Y.—The late Frederick Keteltes willed \$35,525 to Richmond Memorial Hospital and \$20,000 to Staten Island Hospital.

An Opening, Perhaps

The motorist entering Randolph, Mass., is greeted by the sign: "Drive carefully. This town has no hospital."

THE South Nurses Home (left in illustration) of the Millard Fillmore Hospital, Buffalo, N. Y., was changed from a vacuum return line system to a Differential System in March, 1934. The East and West Wings were changed from vacuum return line systems to Differential Operation in the summer of 1935. The South Wing and North Nurses Home were changed from one-pipe systems to one-pipe Differential in the summer of 1935. Four miscellaneous buildings, which include superintendent's house, ambulance building and laundry are still operating as vacuum return line systems.

The Hospital's Carefully Kept Records

Before March, 1934, the consumption rate for all of the above buildings was 3237.3 lbs. of steam per degree day,

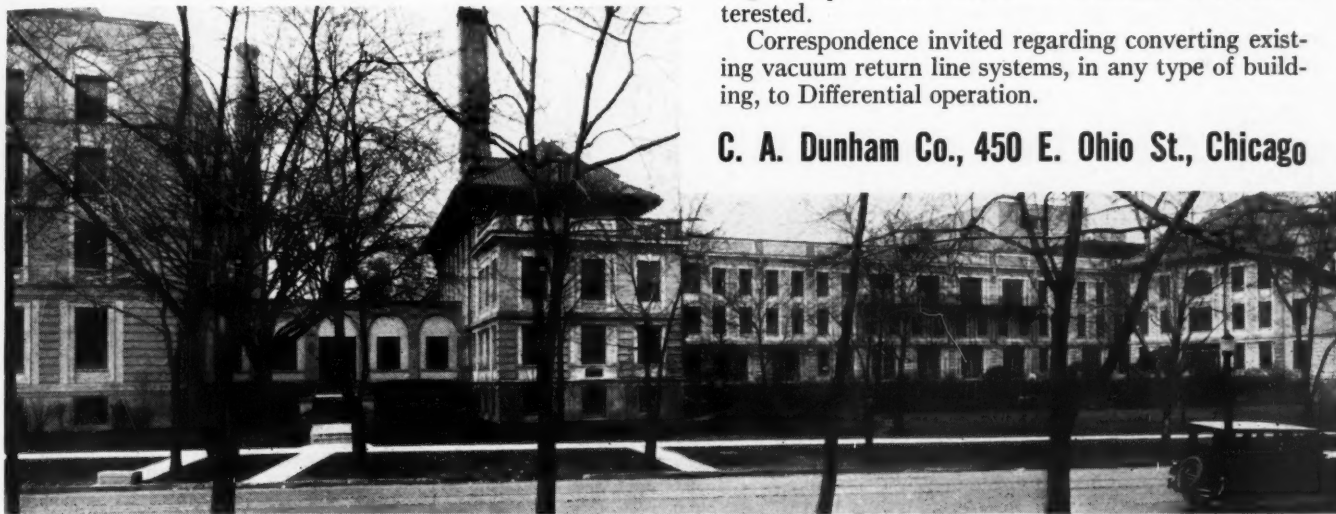
of which the South Nurses Home had a rate of 606.8 lbs. per degree day. The installation and operation of the Differential System in the South Nurses Home from April, 1934, to June, 1935, resulted in a consumption rate of 296.7 lbs. per degree day or a saving of 51%.

The Differential Systems and the four miscellaneous buildings gave a steam consumption rate per degree day of 1983.2 lbs. for the months of September, '35 to May, '36, inclusive. This represents a saving of 38.74% from the previous consumption rate of 3237.3 lbs. per degree day. These records are available to those interested.

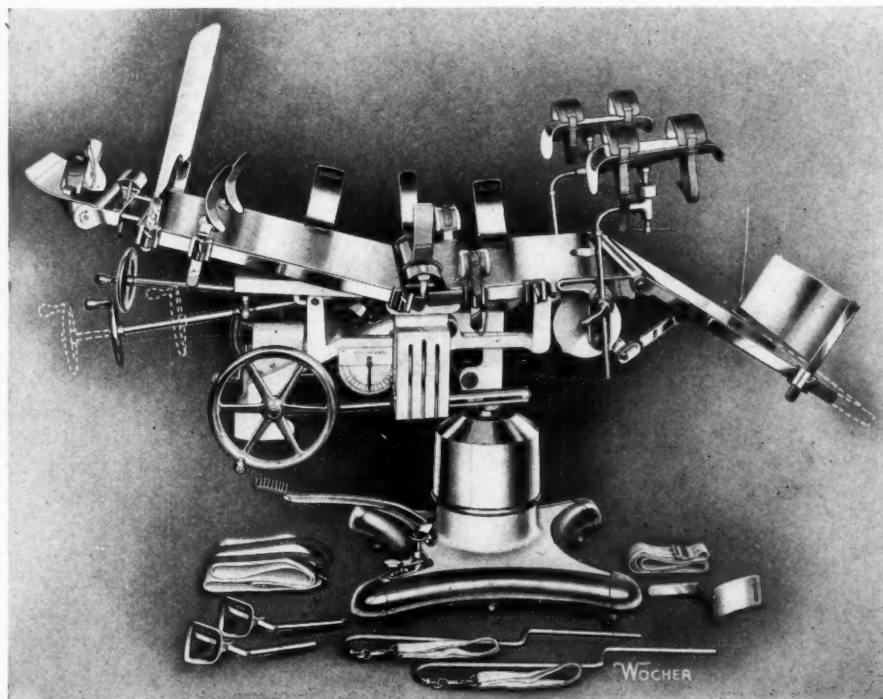
Correspondence invited regarding converting existing vacuum return line systems, in any type of building, to Differential operation.

C. A. Dunham Co., 450 E. Ohio St., Chicago

DUNHAM Differential HEATING



The Year's Outstanding Table... MONT R. REID



Outstanding in

- Appearance
- Design
- Efficiency
- Convenience

That's why we sold more Mont R. Reid tables in 1936 *than any other make or model!* Let us tell you the reason why. Write to

WOCHER'S
THE MAX WOCHER & SON CO.

Surgical Instruments
Sanitary Furniture

29-31 W. 6th St. Cincinnati

LITERATURE in ABSTRACT . . .

Conducted by E. M. Bluestone, M.D. and Joe R. Clemmons, M.D.

Purchasing and Preserving Linen

Their own experiences and those of others, with different manufacturers, have taught hospitals that the goods made by one particular firm are more reliable than the goods made by another, and have influenced them in the purchase of their linen.* This practice has its advantages and limitations.

The ideal way to purchase linen is by specification. Warp and weft thread count per inch, width and length and type of hem are important specifications, but limitations to these variables lead to uneconomic purchase. Tensile strength (the "breaking load" of the fabric in warp and weft directions under a given poundage and conditions) is the most important specification. This cannot be emphasized too much. Fabrics of the same warp and weft count may not have the same "breaking load."

In testing "breaking load" a number of samples of fabric cut in equal sizes and in the same direction should be exposed to an atmosphere of 65 per cent to 75 per cent relative humidity for at least six hours before being used. The type and method of operation of the machine used in the test is an additional requisite. The preliminary examination of the material is simple and includes gross weight, color of fabric (degree of whiteness), depth of hem, size and type of stitching in hem and warp and weft thread count. Whenever purchases of linen are large enough to warrant the expense of laboratory examination, goods should be purchased according to definite specifications and "breaking tests."

Analysis of samples should be repeated after about forty washings under ordinary laundry conditions. Samples of the material found suitable should be kept in the purchasing department. Any material submitted for future consideration should bear the manufacturer's label. A card index of purchases giving date, quantity and price will prove useful.

Precautions against any impairment of the durability of linen include washing in soft water with bland neutral soap, multiple rinses and careful use of bleach and sour. "Built soaps" are satisfactory for use at a cost of more than twice a 98 per cent pure anhydrous soap. It is more economical to purchase a 98 per cent pure soap and add builder. All soaps should be analyzed frequently.

The removal of stains affects the

durability of linen. The methods recommended by the National Research Council are as follows:

Balsam Peru: Brush 20 per cent oleic acid and denatured alcohol well into the stained portion of the fabric; allow to stand one hour. Immerse in solution of ammonia and work well. The oleic acid penetrates the fibers and when treated with ammonia solution forms a soluble ammonia soap. Products of oxidation of balsam resist complete removal.

Ferric Ammonium Citrate: Agitate stained material with 1 per cent aqueous solution of oxalic acid at 140° F. for ten or fifteen minutes. The stain (largely iron oxide) is readily removed.

Protargol: Saturate the stain thoroughly with iodine solution and allow to stand ten minutes. Rinse in sodium thiosulphate (hyposulphite) solution, then rinse in water.

Effective treatment of stains upon tensile strength are tested by means of the "permanganate number." Permanganates are oxidizing agents and decolorize upon reduction. They are reduced by different fibers (silk, cotton). The degree of reduction depends upon the type and condition of the fiber. The latter changes with change of tensile strength and is an approximate index of the degree of alteration of the tensile strength, providing the tensile strength of the new fiber is known. It is necessary to know the reducing properties of the different types of fiber (silk, cotton) to evaluate this test properly.

*Mackenzie, John C.: Practical Considerations in the Purchase and Preservation of Linen. *Canad. Hosp.* 13: 6 (Aug.) 1936. Abstracted by Joe R. Clemmons, M.D.

Health Through Employment

The statement of Galen that "employment is Nature's best physician and essential to human happiness" indicates the ancient appreciation of occupational therapy.* Every patient who is physically able requires and is entitled to a reasonably full program of work and recreation. The therapeutic value is largely dependent upon the active participation of the patient. Sufficient variety of work and recreation must be made available.

The types of recreational work available are craft therapy, domestic therapy, industrial therapy and husbandry.

Craft therapy involves the development of special interests and aptitudes

in such work as toymaking, wood carving, leather and metal work and bookbinding.

Domestic therapy includes minor nonroutine duties about the hospital.

Industrial therapy involves work simulating activities of outside commercial organizations, e.g. laundry, sewing room.

Husbandry is agricultural therapy and relates to care of gardens and farm work.

A classification of patients designed to fit most of them into one of the above forms of occupational recreational therapy yields the greatest value because of mutual stimulation by various patient achievements. Formation of homogeneous groups and interchange of patients as individual circumstances dictate constitutes the most efficient form of large scale therapy. The mental state, physical condition and individual prognoses are important grouping factors.

The need for physical exercise and socialization through group activity makes the assignment of women to outdoor activities of equal importance to that of men.

*Israel, Robert H., M.D.; Rosenzweig, Leonard, M.D., and Urbaitis, John, M.D.: A Balanced Program of Occupational-Recreational Therapy. *Occup. Therapy* 15: 19 (Feb.) 1936. Abstracted by J. Masur, M.D.

Needs of the Hospital Laboratory

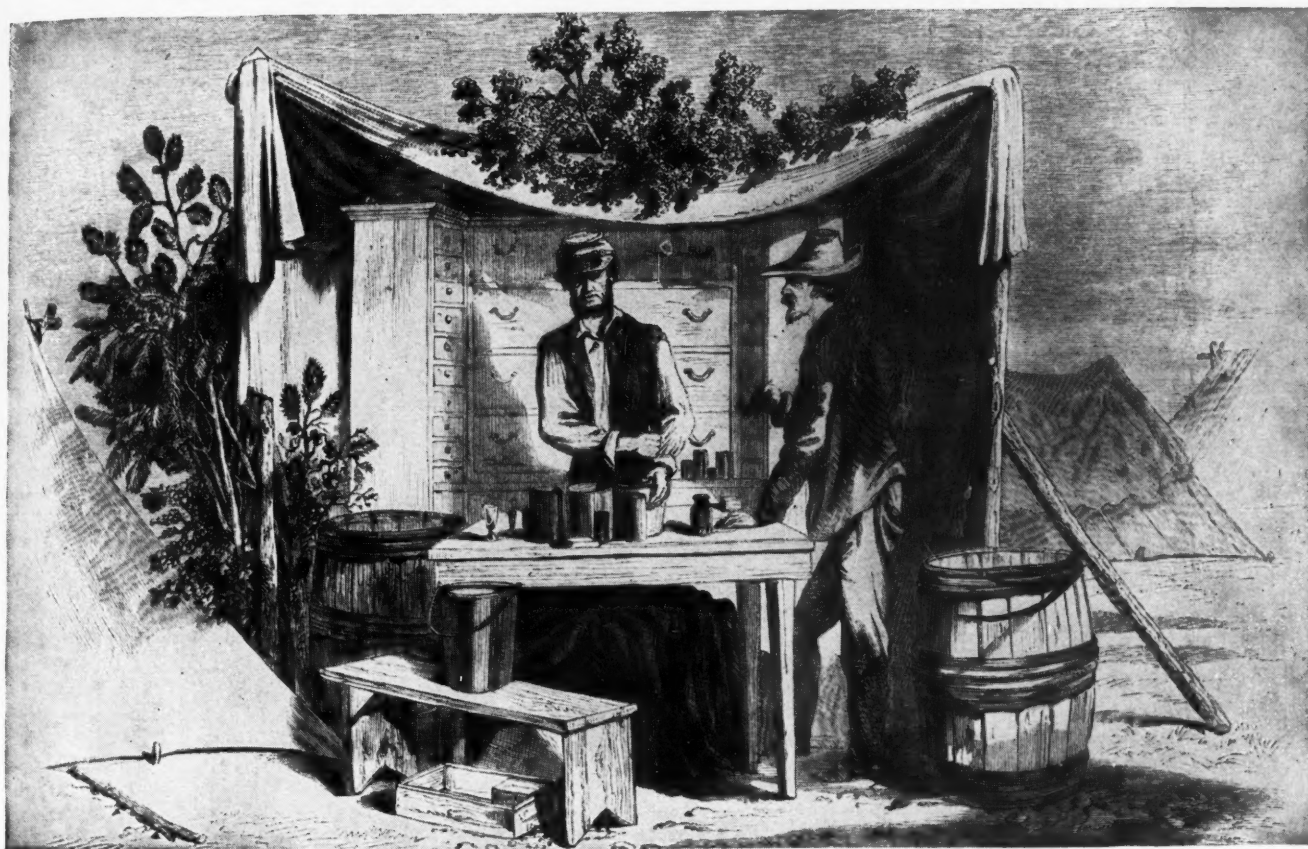
An accredited full-time clinical pathologist is the sine qua non of a modern, efficient laboratory in a hospital of moderate size, and qualified technical assistants contribute to smooth functioning in the set-up.* A flat rate laboratory fee is important in that it allows a margin of freedom for the clinician in securing laboratory analyses for his patient. Research accomplishment is the real mark of distinction in a hospital laboratory.

The department of pathology at St. Luke's Hospital, Duluth, Minn., encourages close correlation of clinical and postmortem findings. The success of the cooperative effort is manifested in an 80 per cent necropsy average. Preservation of interesting specimens, a variety of tissue stains and a detailed accurate description of pathologic findings with photographs, are all indispensable in a well ordered department of pathology. Routine gross and microscopic examinations are made on all surgical specimens. Frozen section service is available at all times. The use of the word "normal" is avoided in operative specimens, mostly for legal reasons.

Hematology should include bone marrow studies. The bacteriology laboratory possesses a filter, potentiometer and facilities for vacuum preservation of organisms. Complete technical equipment for bacteriologic

Before Lincoln Freed The Slaves

Hospitals Depended on Webb's Alcohol



Culver Service

FIELD HOSPITAL IN '61

Rough and crude though they were, the field hospitals of the Civil War were none the less effective stop-gaps for the tides of waning fighting strength. A chest of drawers, a table and a bench, a couple of barrels, probably one of which was used to mix antiseptics, did yeoman service in keeping alight the spark of heroism.

BLOOD ran hot on the battlegrounds of Shiloh and Bull Run. Brother fought brother in a mighty conflict that threatened to cleave the Union. Behind both lines army field hospitals were first havens for the wounded.

With the number of medicaments at a bare minimum doctors dared choose only the most essential. One of these was alcohol and, in many cases, Webb's Alcohol.

Since 1835, a quarter of a century before the Civil War, the House of Webb had been supplying the country's leading hospitals with high grade alcohol. For over a century Webb's alcohol has been the "Standard of Quality."

In 1915 the firm of James A. Webb & Son became a part of the U. S. Industrial Alcohol Co. Their eighty years' experience was added to our modern technical knowledge. Their reputation for pure and uniform alcohol is our sacred trust.

Today, Webb's and U.S.I.-U.S.P. are the best-known and most widely used brands of alcohol. The country's leading

hospitals select U. S. I. products because of their uniform high quality and consistent purity. You, too, can depend upon U. S. I. to fill your alcohol requirements.

Charts illustrating a simple method for determining the amount of 190 proof alcohol in 54 gallon drums by stick measurements can be secured by writing to U.S.I.



ALCOHOL

U.S.I.-U.S.P. WEBB'S

ONE HUNDRED YEARS OF SERVICE TO HOSPITALS

U.S. INDUSTRIAL ALCOHOL CO. 60 EAST 42ND STREET, NEW YORK
BRANCHES IN ALL PRINCIPAL CITIES

cultures and all serologic tests are available. A wide variety of chemical analyses for routine, emergency, and research are offered.

Some provision for the familiarization of interns with the laboratory should be made without burden either to the physician or to the laboratory.

*Wells, Arthur H., M.D.: The Organization of a Hospital Laboratory. J. A. M. A. 107: 1351 (Oct. 24) 1936. Abstracted by J. Masur, M.D.

Need for a Hospital Pharmacopoeia

No hospital can afford to overlook the economies and improved results following rationalization of drug therapy by adoption of a pharmacopoeia.* So-called "ethical" prescription specialists have increased. The Committee on the Costs of Medical Care reports an increase in value of prescription specialties in the United States from twenty million dollars in 1921 to fifty-six million dollars in 1929.

The United States Department of Commerce national drug store survey reports that from 1928 to 1931 inclusive, 158 manufacturers introduced 566 new proprietary remedies. Doctor Gutman reports 1,040 drugs of known constitution in 1,980 different forms; 492 combinations in 610 forms; 346 preparations of undeclared composition; 642 topical applications; 860 endocrine products in 1,523 forms; 1,563 hypodermic medicaments; 535 biologicals in 985 forms, and 209 medicinal foods. From twenty to fifty different proprietary treatments are listed in almost every important therapeutic group and many approach or exceed 100. Quarterly supplements describe from forty to fifty items.

In a report of the national drug store survey the following significant statement appears:

"In approximately 35,000 prescriptions filled by pharmacies in St. Louis, during the twelve-month period from May 1, 1930, to May 1, 1931, only 22 (17.5 per cent) of the 126 new remedies marketed in 1929 appeared at all. Of the 134 new remedies introduced in 1930, only 17 (12.7 per cent) were prescribed in the 35,000 prescriptions. Of the 122 new specialties marketed in 1931, only 12 (9.8 per cent) appeared in the prescriptions studied. If the St. Louis situation can be said to be typical of the whole United States, we can then assume that on an average only 13.4 per cent of the new proprietaries being marketed are prescribed to any appreciable extent."

"New and Non-Official Remedies" of the American Medical Association lists almost 600 items. New additions are balanced by omission of products which are exploited beyond reasonable limit or have failed to prove their merit.

Cost studies are possible in the case of official chemicals which are also

marketed as specialties. Pharmacopoeial standards are high and any difference in quality which may exist between an official chemical and its proprietary equivalent are usually in favor of the former. The cost of proprietary articles is commonly from three to five times that of the official chemical.

Ceaseless propaganda which foists upon the profession a number of unnecessary and inferior remedial agents and not excessive cost is the most serious aspect of the situation. The physician is inclined to experiment with these, to the neglect of established drugs and preparations with the performance and limitations of which he is more thoroughly familiar and which he could employ with greater intelligence and skill. The hospital, by keeping before its physicians a reminder of the virtues of established remedies of proved therapeutic merit, effects economies and improves medicinal treatment. There is no denying, however, that important and valuable drugs have entered the materia medica via the proprietary route. Those of outstanding merit have been a pitifully small proportion of the whole.

The British Pharmacopoeia and the Canadian Formulary which supplements it are served and advised by the most competent medical and pharmaceutical authorities throughout the British Empire. Between six and seven hundred drugs and preparations, officially recognized and carefully standardized, are listed by these two standard authorities. Frequent and regular revisions and supplements provide recognition for new discoveries as soon as their value is firmly established.

A hospital pharmacopoeia, by suggesting convenient dosage forms, rational combinations and attractive flavoring, can do much to further the prescribing of official products.

*Woods, E. L.: The Advantages of An Official Formulary for Hospital Use. Canad. Hosp. 13: 10 (Aug.) 1936. Abstracted by Joe R. Clemmons, M.D.

Health Insurance and State Medicine

*Fortune** made a survey of 4,500 persons of various ages and classes in an effort to ascertain their attitude toward voluntary health insurance and state medicine.

Three questions were asked: "Would you be willing to pay \$10 a year for each member of your family to cover hospital expenses for a year?" "How much money has your household spent during the past year for doctors and hospital bills?" "Do you believe the government should provide free medical and dental care at the expense of the taxpayer for persons who cannot pay?"

The results of the first question

were: yes—47.9 per cent; no—44.3 per cent; don't know—7.8 per cent. The second question revealed that 8 per cent of the families interviewed spend \$100 to \$199 a year for medical services, and 10.7 per cent spend \$200 or over for their annual medical bill. On the other hand, 58 per cent spend less than \$25 a year for medical services, but these constitute 50.8 per cent of those who would be willing to pay \$10 per person to cover hospitalization. The acceptance runs with fair evenness through all economic levels, but it is heaviest, with slightly more than 50 per cent, in the middle classes.

The same questions were asked about dental service, the results showing that 71.7 per cent of U. S. households have no yearly dentist bill or pay under \$25 for dental care. Only 43.3 per cent would be willing to pay \$10 annually for dental care against 49.4 per cent who said they would not.

It may be concluded that there would be wide acceptance, representing around half the population, of both medical and dental health insurance at \$10 per person, and that if all the people who like the idea were to be enrolled in health insurance schemes, they would probably pour into the medical and dental business more money in membership fees than they are now spending. This may mean that the idea in its broadest application would have a sound actuarial foundation and would financially strengthen the service of American health.

However, the question of socialized medicine is by no means disposed of as shown by the answers to the third question regarding free care provided by the government for those who can't pay. Seventy-four per cent of those questioned were in favor of it, with only 20.3 per cent against. The prosperous, who are the chief taxpayers, agreed 65.3 per cent with the majority. This indicates an impressive body of opinion among all classes in favor of extending government health service from the preventive to the clinical. It is the force of this sentiment that gives push to the advocates of socialized medicine.

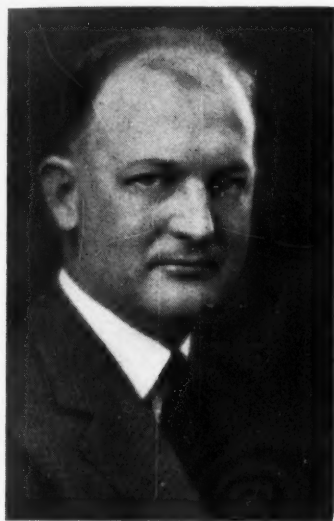
*Doctors, Dentists and Dollars, *Fortune* 14: 221 (Oct.) 1936. Abstracted by Jane Barton.

Social Work—Its Past, Present and Future

John A. Kingsbury here looks back on a period of thirty years spent in social work, particularly in the public health field, and comments on the present trends in this profession.* He feels that social work should not be restricted in its scope, but should concern itself with the causes and solutions of our cyclical crises. Social workers, he states, are developing a

Again in 1937~

Sabor of the Midland



Mr. Sabor of Minneapolis, a widely-known Philatelist, possesses a valuable and complete collection of Commemorative Stamps.

*A*mbassador of MIDLAND good will for twenty-five years—this is the distinction earned by RUSSELL SABOR.

The names of SABOR and MIDLAND are synonymous with the quality that has made such products as Germolyptus, Lacqairlustr, Lohador (Surgical Soap), Babeoleum, and other MIDLAND products the standard of the Hospital World.



Over a Third of a
Century of Service

Midland
CHEMICAL LABORATORIES ^{INC.}
DUBUQUE IOWA

better understanding of the underlying causes of these crises and are taking an active part in the program for social security.

He speaks of the progress made by both public and private welfare agencies in organization, administration and policy. Special mention is made of the development of councils of social agencies, such as the Welfare Council of New York City, and the cooperation of such public agencies as the FERA and TERA with private welfare agencies. He lauds the difference between present day cooperation and the trend toward consolidation of public health agencies with the spirit of yesterday and its competition of committees interested in the same social problems. The health center development in New York City and the county health developments in such counties as Cattaraugus and Westchester are examples of a modern comprehensive health program. He looks forward to the time when public welfare departments and public health departments will assume the major responsibility for a large part of the social work that must be done.

Prominent people have entered this field and it has been proved that public agencies are able to draw well trained workers. In the national field, too, innumerable leaders have distinguished themselves in administering the social security acts.

Today social work has established itself as a profession and real training is required in schools for this purpose. Definite standards have been established and a truly scientific attitude has been developed toward all problems in social work. The appraisal of this work is done on a qualitative as well as a quantitative basis and there has been a clearer evaluation of the problems involved. Funds have been made available for research work, such as a fund of \$3,000,000 through the WPA to study the effect of the depression on the health of the people. The men and women supervising this work must be of the highest calibre with the necessary education and experience.

Mr. Kingsbury stresses the fact that social workers should be given full sway in their work and should discourage any attempt of a board of directors or of contributors to control the character and quality of their work for selfish interests.

*Kingsbury, John A.: Trends in Social Work as I See Them. Quart. Bull., N. Y. S. Conf. Social Work, Sept., 1936. Abstracted by Minnie Smith.

Medical Changes in Britain

Necessary and unavoidable changes in medicine ought to be guided by physician organizations. *There have been revolutionary changes recently in the attitude of the public and state

towards questions of national health, resulting in the creation of many new and poorly coordinated auxiliary medical agencies. Collective security demands the pooling of resources and intelligent cooperation of the manifold voluntary and statutory medical organizations.

Time is an indisputable premise to the practice of good medicine, particularly if emphasis is to be placed on the detection of early ailments. The necessity of earning a living wage in practice compels the undertaking of more work than can be safely handled in available hours. Health centers with personnel and special equipment for skilled diagnosis and treatment are now readily accessible to large surrounding areas of population.

General practitioners in the area should be intimately associated with these health centers, with specific functions to perform and with resultant improved efficiency and continuous contact with modern advances in medicine. The governing board would coordinate all preservative, preventive and curative services in the district to avoid waste and overlapping, assuring the public that voluntary and levied contributions are used to the best economic advantage.

Despite the development of so many specialties, the general practice of medicine should soon assume an even more important function in the health of the community. The saving of life has been relegated to institutional team work, whereas the saving of health and prevention of illness must be initiated by the general practitioner. Practitioners should staff the preventive and curative medical services which have been diverted to the control of public health authorities.

The difficulties of eking out an existence in research under present arrangements have not been conducive to the encouragement of promising candidates in this field. Included in the activities of every large health center should be a department of research with specially trained full-time physicians for the investigation of clinical problems.

Large medical schools would continue to educate candidates for general practice as modified under the system of regional medical services. Candidates for consulting and teaching positions would supplement their three years of clinical training by postgraduate courses in special departments, or by working two or three years in a research institute. A limited number of capable and qualified students, graduates of a special school, would continue to devote all their time, properly compensated, to research.

*Buzzard, E. Farquhar: And The Future. Brit. M. J. 2: 163 (July 25) 1936. Abstracted by J. Masur, M.D.

Help for the Aged

Half of the 42,000,000 persons employed in this country will be exempt from federal pay roll taxes which start on January 1, 1937.* The other half will make a payment of 1 per cent of their salaries and wages, which, in years to come, will rise to 3 per cent.

The exempt group is made up as follows: farmers and farm workers, 11,000,000; self-employed and professional workers (including workers in nonprofit hospitals), 5,500,000; domestic help and personal servants, 2,500,000; casual workers and seamen, 1,000,000; state and local government employees, 1,000,000.

For this group, employers are not required to make payments equivalent to the amount which would otherwise be deducted from earnings. While no provision is made for this group under the Social Security Act, forty states, with funds provided equally by the states and the federal government, provide up to \$15 each, or a total of \$30 a month for pension purposes, to each aged person who lacks an income sufficient to support himself. The latter plan, of course, corresponds to an old age dole and is limited to those actually in need of support.

Under the new act no payments are to be made before 1942, and then only to workers who reach the age of sixty-five who give up their jobs.

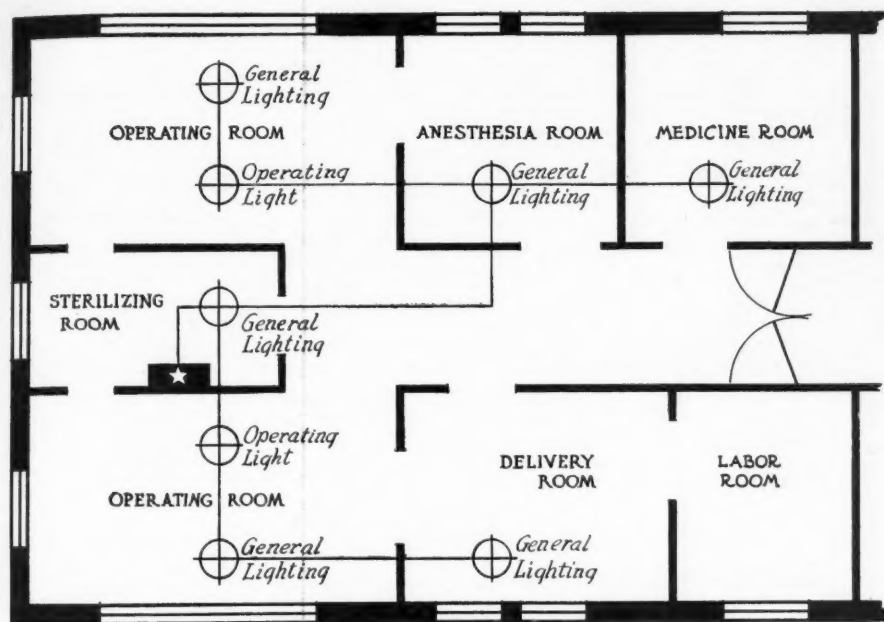
If a worker is now sixty years of age and earning \$1,000 a year he will be entitled in 1942, if he quits work, to an annuity of about \$17 a month. Or, if now forty-five and earning \$100 a month, he could save enough by the time he was sixty-five to be entitled to an annuity of \$32.50 a month. The maximum annuity for a person earning \$3,000 a year for forty years is \$85 a month.

The old age dole or pension plan is now in operation and eligible persons (those above an age set by the state making the rule) are drawing pensions up to \$30 per month for single persons, and \$60 for married couples. A portion of the taxes paid under the new plan may, in fact, provide funds for pension purposes for those under the dole system. The author points out that a reconciliation of these two systems promises to become a major problem.

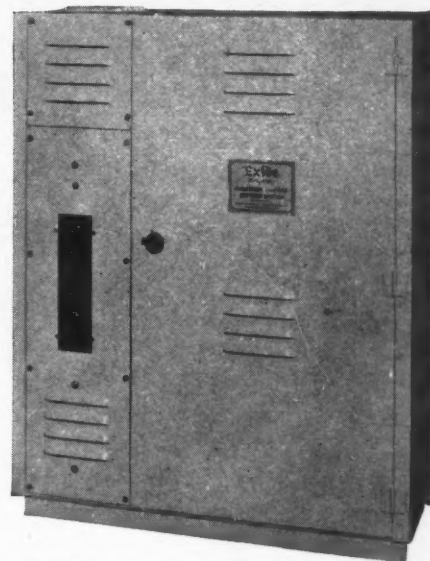
Note: If the author, who confined himself solely to a statement of facts, had ventured any comment, he could mention the growing dissatisfaction among the workers of charitable and religious organizations, who will be required to seek relief, if necessary, under the stigma of an investigation and a dole rather than obtaining it as a right.

*Social Security Pension Plan. U. S. News, Nov. 28, 1936. Abstracted by J. Goodfriend.

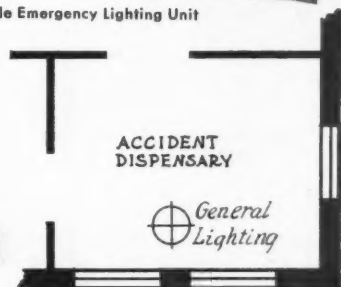
NEW Exide Emergency Lighting System



★ Location of the Exide Emergency Lighting Unit



The Exide Emergency Lighting Unit



... engineered for smaller hospitals

NOW for \$265 you can get a completely automatic self-contained Exide unit that gives split-second emergency lighting protection for operating rooms (operating lights as well as general illumination), anesthesia room, sterilizing room, medicine room, delivery room, accident dispensary... all simultaneously.

The need for such protection is well recognized. Utility companies take every possible precaution to prevent interruption of the normal electric current supply, but the effects of storms, floods, fires, street accidents, or short circuits and blown fuses within the affected building are often beyond human control.

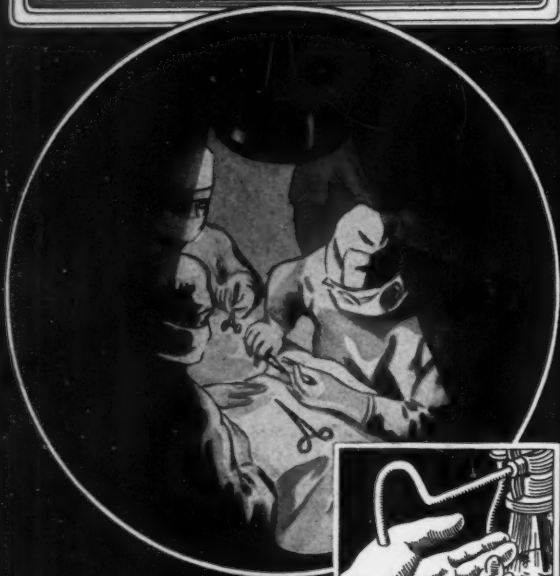
This new Exide Unit requires no care or attention, except to put water in battery cells two or three times a year. It is easy to install, and the price is only \$265. Larger, 115-volt systems, are proportionately low in cost. Exide Engineering Service is gladly supplied free. Write for illustrated Bulletin on Exide Emergency Lighting for Hospitals.

THE ELECTRIC STORAGE BATTERY CO., Philadelphia
The World's Largest Manufacturers of Storage Batteries for Every Purpose
Exide Batteries of Canada, Limited, Toronto

Exide
Keepalite
**EMERGENCY LIGHTING
SYSTEMS**

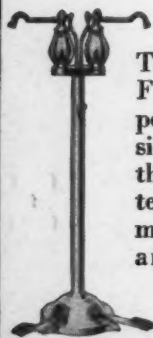
GERMA-MEDICA

AMERICA'S FAVORITE SURGICAL SOAP



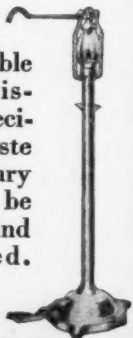
before any incision

In the scrub-up, Germa-Medica flushes out bacteria and dead tissue. It leaves the hands surgically sterile for operating, reduces dangers of infection. Yet the penetrating lather, containing olive oil, never irritates. That's why four out of every five hospitals use Germa-Medica.



The Levernier Portable Foot Pedal Soap Dispensers* act with precision. Without any waste they provide a sanitary technique. They can be moved where desired, and are easily sterilized.

*Furnished free to quantity users of Germa-Medica.



HOSPITAL DEPARTMENT
The HUNTINGTON LABORATORIES Inc.

DENVER HUNTINGTON, INDIANA TORONTO

BOOKS ON REVIEW

MEDICAL POLICIES AND PROCEDURES FOR THE RESIDENT STAFF OF THE ALAMEDA COUNTY HOSPITALS AND CLINICS. By Benjamin W. Black, M.D. Oakland, Calif.: Alameda County Hospital, 1936.

The complexities of hospital organization, the interrelationships of many departments, the necessity of having orderly mechanisms for the conduct of professional and other services, particularly in larger institutions, make it highly desirable to have a manual in which policies are definitely set forth and procedures and techniques routinely used are described for the guidance and instruction of professional staff and personnel.

A number of institutions have found it helpful to have booklets of this type to give newly appointed members of the resident staff or interns for study before they enter upon their term of service.

Doctor Black, after using a mimeographed form for a number of years, during which time many changes, additions and corrections were made, has now prepared and published an excellent manual for the use of the resident staff of Alameda County Hospitals. While this manual is primarily intended for and is therefore applicable in its entirety only to these hospitals, administrators will find it helpful if they plan to prepare similar information for use in their institutions.

The chapters pertaining to the professional services, the routine procedures prescribed by the medical staff for use as diagnostic and therapeutic measures, the dietary lists, formulary and other similar chapters will readily serve as a guide to those planning similar publications. The material can readily be modified to meet local conditions and requirements. House officers and interns find such manuals most useful when they contain, in addition to rules and regulations governing conduct, relations and duties, a compilation of valuable information such as Doctor Black's manual contains. When that material is published in a convenient form, so that it is readily available for reference, it is of increased value.—ARTHUR C. BACHMEYER, M.D.

PRINCIPLES AND PRACTICE OF RECREATIONAL THERAPY FOR THE MENTALLY ILL. By John Eisele Davis and William Rush Dunton, Jr., M.D. New York City: A. S. Barnes and Co. 1936. Pp. 206, \$3.

The title and the introduction of this book lead one to expect emancipation from narrowness of viewpoint, from rigidity and formality. The book does not live up to this expectation. In the first place it is difficult to read. Throughout one is given general statements which need specific development or elucidation, but soon another generalization is set forth and the anticipated elucidation never appears. Again, in large measure the words are psychiatric but their meanings are obscure. A great many quotations from authorities are used but the context hardly supports or develops them. The general tone and effect of the book are formal and lacking in vitality.

It is difficult to see to whom the book would appeal. For the recreational worker the psychiatric insight is poor. Ingenuity, spontaneity and individualization are lacking. It may suggest certain working lists. It does not enlighten the psychiatrist as to what he may expect from the recreational worker. The authors may have more in their practice than they have in their book. The written effort lacks sincerity, comprehension, vitality. This is a field that needs such a touch. The book does not have it.—THOMAS P. BRENNAN, M.D.

The
Newest Product
of
Corning Research

FIBROUS GLASS

THE latest achievement of Corning Scientific Research is fibrous glass. Melted by glass tank methods, spun into fibres of near microscopic fineness, these Corning Fibre Products possess qualities hitherto unavailable. They are resilient, tough, soft and pliable.

For use as a filtering medium in laboratory work, two compositions, both lead and borax free, are now available. Although both types of wool are identical in physical characteristics, "PYREX" High Stability Wool is superior in chemical stability.

"PYREX" HIGH STABILITY WOOL—*Catalog No. 9930.* Made of "PYREX" brand Fibre Glass No. 719, it is recommended for use where solubility or pH are critical factors. Its fibre diameters vary between 0.0002" and 0.0003".

"CORNING" STANDARD WOOL—*Catalog No. 9940.* Its fine fibre diameter (0.0002" to 0.0003") makes for increased filtering efficiency and ease in handling. Made from "CORNING" brand Fibre Glass No. 008, it is chemically comparable to the better grades of glass wool now commonly used.

Both types of wool are supplied in sheet form in convenient half-pound rolls with 24 rolls in each original package. The sheets are approximately one-eighth inch thick and ten inches wide.

These items are available and samples may be obtained through your regular dealer in "PYREX" brand laboratory glassware.

Cat. No.	Description	Code Word	Lbs. per Pkg.	Net Price per lb.	NET PRICE PER PACKAGE			
					1 pkg.	25 pkgs.	50 pkgs.	100 pkgs.
9930	"PYREX" HIGH STABILITY WOOL, made from "PYREX" brand Fibre Glass No. 719.	CQOSU	12	\$2.20	\$23.76	\$22.57	\$21.38	\$20.20
9940	"CORNING" STANDARD WOOL, made from "CORNING" brand Fibre Glass No. 008.	CQOUQ	12	1.30	14.04	13.34	12.64	11.93

Laboratory & Pharmaceutical Division of
CORNING GLASS WORKS, Corning, N. Y. • Manufacturers of "PYREX" Brand Glassware

DON'T BURN UP YOUR DRESSINGS!

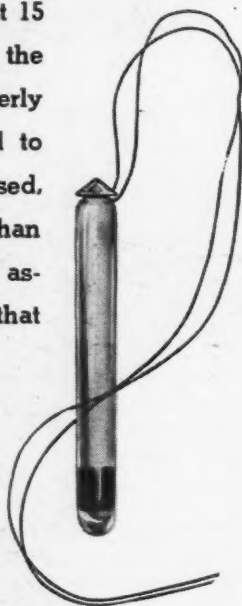
Thousands of dollars are wasted by hospitals operating sterilizers at higher temperature-time ratios than necessary. Dressings are browned, indicating the strength of fibre has been weakened. Such goods are unfit for Hospital use.

Much lower temperature-time ratios may be used with safety when a Diack Control is placed in the load to check the efficiency of the sterilizing operation.

Recall that Diacks fuse at 15 lbs. pressure so long as the sterilizer is working properly and heat has penetrated to the heart of the load. So used, Diack Controls more than pay for themselves and assure the user at all times that his dressings are sterile.

Sealed in glass—the Diack chemical cannot contaminate your dressings.

12 inch threads attached—for proper use and ease in checking the sterilization.



Box of 100—\$3.60 Post Paid

★ ★ ★

A. W. DIACK CO.
5533-37 Woodward Avenue
DETROIT, MICHIGAN

TIME-TRIED
Diack Controls

NEW PRODUCTS • • •

Double Service for Your Dollars

A double feature attraction is offered by General Electric X-Ray Corporation, Chicago, with the Model R-36 diagnostic x-ray unit. The two features in question are radiographic and fluoroscopic service combined in one complete unit. This apparatus, new and unique in the history of x-ray apparatus design, says General Electric X-Ray, provides the most practical diagnostic service ever devised.

Two high voltage transformers are used—one for radiography, the other for fluoroscopy. The radiographic transformer is mounted on the same side rail as the tube stand, and travels with it. Protection against high voltage shock is obtained by the use of specially insulated high voltage cables connecting the transformer to the shockproof tube unit mounted on the tube stand. The transformer is said to be efficient over a wide range of electrical ratings. The fluoroscopic transformer is mounted immediately under the table top. It is the shockproof tube head in which both the transformer and coolidge tube are immersed in oil.

The Model 36 table which combines with the Model R generating unit to make the R-36 unit provides, the manufacturers assert, the utmost in convenience in handling the tables. The table also permits of full-length fluoroscopy, its 77 inches of length and 41¼-inch longitudinal travel of the fluoroscopic tube making it possible for six-footers to come within the range of travel of the central fluoroscopic beam.

Where it is desirable, the units may be used independently for specialized work or for use with existing equipment.

Foot Press Operates at Finger's Touch

Remember way back when the family flatirons were heated on the stove in relays, one being used while the other was heating? It took a strong right arm to handle the things. Now, what with people like Troy Laundry Machinery, a division of American Machine & Metals, Inc. (New York City), offering the new Minute-Man foot press which operates, they say, at the lightest touch, laundry workers will be getting positively sissified.

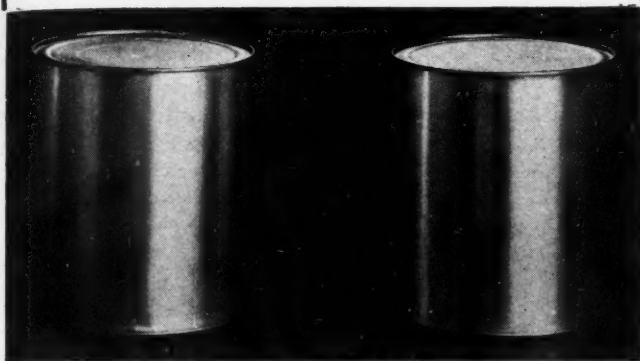
Effortless ease of operation is not the only claim made for the new foot press. It is made of welded steel which is light in weight but said to be stronger than cast iron, and there are only four moving parts connecting the head and treadle which, in mechanical language, means less wear and less upkeep expense. For further details, consult Troy who will be glad to send you a copy of the new Minute-Man folder entitled "Light as a Feather to Operate."

Quality Labeled

By their labels you shall know them. No longer need the purchaser harbor any doubts about the quality of the steel filing equipment, desks or tables he is acquiring, for shortly all equipment of this type will carry a label guaranteeing that the customer is getting exactly what he is paying for.

The Steel Office Furniture Institute has issued to its members in good standing labels to be applied to the various grades of their merchandise which have been inspected and classified by the institute. These labels represent the institute's guarantee that the various grades of steel files

"Operate"



FRUITS without Sugar

Also of interest is a fine and varied selection of solid pack pie fruits, under our Red Lily Label.

A selection of Dietetic fruits and vegetables is also provided under the Monarch Label.

Here's the way to convince yourself of the greater value offered you in Monarch Finer Foods . . .

Take the labels off two No. 10 (Institution Size) tins of any given fruit or vegetable, and open both cans. Compare the contents of the two tins, as to weight of solids, number of servings, quality, color, flavor, fill, and uniformity. That's the only way you will ever know how well

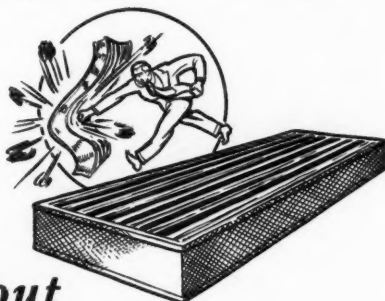
MONARCH FINER FOODS

can serve and please you. The extreme care used in growing, harvesting, grading and packing, matches the "hospital care" you use in serving.

Phone (SUPERior 5000) or wire, or write for representative to call.

Institution Department

REID, MURDOCH & CO., Dept. MH-1
Chicago, Ill.
"Quality for 84 years"



About MATTRESS USE

Most everybody knows that *hair* is the most comfortable, durable and sensible mattress material. Now there is a substantial *improvement* in the use of hair in hospital mattresses.

The Sta-Woven Method of evenly distributing hair, then mechanically interlacing it, makes a mattress pad of curled hair which while supremely resilient and comfortable, is also most hygienic. Removed from its cover, it is as readily *washable* as a *turkish towel*—as *durable* as a *turkish rug*.

Especially EASY and CHEAP to Renovate.

Gladly will we send information, as to this NEW hospital mattress.

PERROTT & HARRY

401 North Broad St.

Philadelphia, Pa.

We need two or three good Representatives acquainted with hospital and institution trade to handle this INNOVATION. Fine income assured. Write.

Gorham



MANUFACTURES
A COMPLETE LINE
OF HOSPITAL
SILVERWARE

Write for Samples
and Prices



THE GORHAM COMPANY

HOSPITAL DIVISION

New York, 6 West 48th St.

Chicago, 10 S. Wabash Ave.

San Francisco, 972 Mission St.



Made Right Priced Right

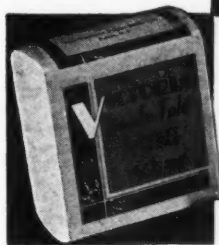
VICTORIA SINGLE FOLD

White, absorbent, sanitary. 1000 single fold sheets, 4½" x 5", for dispensing two sheets at a time from cabinets. (See below)



BLACK CORE ROLL

White or manila, silky in texture, in either 2000, 3000, or 4000 sheet rolls. Three sizes: 4½ x 4½, 4½ x 4¾, 4½ x 5. (See left)



VICTORIA DOUBLE FOLD

White, manila or full bleached. 800 interfolded sheets per package, dispensed two sheets at a time from cabinets. 125 packages per carton. 3 sizes: 4 x 5¾, 4½ x 5¾, and 5 x 5¾. (See right)



Let Us Send You Samples

Victoria TOILET TISSUES

VICTORIA PAPER MILLS COMPANY

Founded 1880

FULTON,

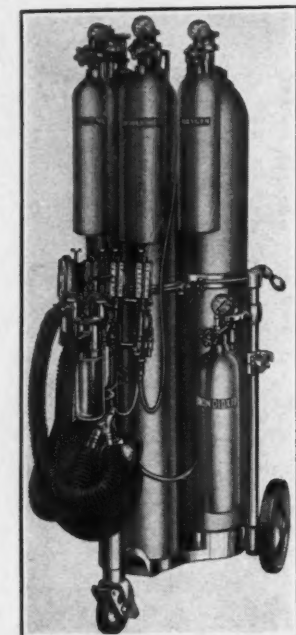
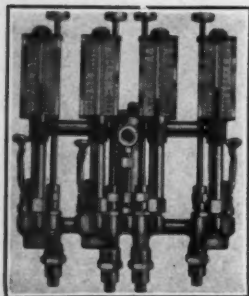


NEW YORK

HEIDBRINK

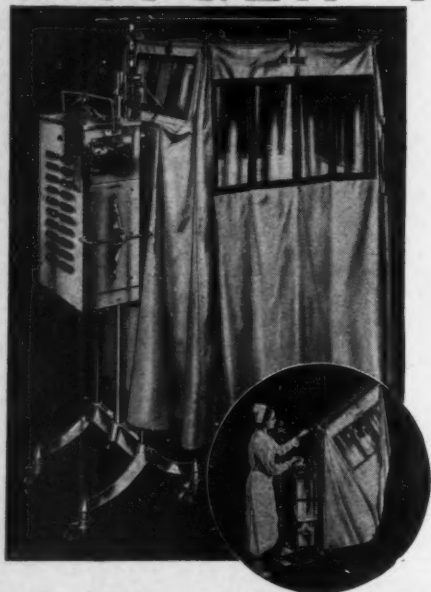
APPARATUS FOR GAS ANESTHESIA

The unequalled performance of the Heidbrink Kinet-O-Meter insures better results, at greatly reduced costs. Its many features simplify administration and develop the confidence of the operator.



Simple dry-float flowmeters (shown at left) control, measure, register and deliver each gas independently and accurately.

OXYGEN TENTS



Three models—two motorized and one motorless—are presented for 1937. They embody many innovations and every feature of practicability.

Any nurse can perform every duty incident to the application, operation and adjustment of any Heidbrink Tent.

Descriptive literature free upon request.

HI-CO

THE HEIDBRINK COMPANY
MINNEAPOLIS MINNESOTA

and desks comply with the minimum specifications for each grade, drawn up by engineers in the industry and approved by institute members. The standard grade "A" products, for instance, will carry a blue label, utility grade "C" will carry a green label.

The institute feels that many benefits will accrue from this service. Misrepresentations as to the grade of files should, they say, be pretty much eliminated. Competitive quotations can be more easily and accurately checked and the customer can easily determine just what grade of equipment he is buying and paying for.

Lights! Action!

Business must go on as usual in the hospital, come flood, hurricane or blizzard, and as the best regulated electrical system will break down occasionally under such circumstances, an automatic storage battery that will go into action pronto in case of power failure is practically a necessity. Gallant doctor saving the life of the hero with an emergency operation by candle light is all very well for the movies, but it's bad business for the real-life hospital.

There's a new 12-volt Exide emergency lighting system (Electric Storage Battery Company, Philadelphia) especially designed for small and medium sized hospitals. This system will, the manufacturers assert, provide automatic split-second protection whenever normal electric service is interrupted. Upon interruption of the regular service, the Exide system automatically furnishes light from lamps of its own, permanently installed, circuits which include operating room lights that are normally used during every operation. Other emergency circuits protect additional rooms where emergency light is important or desirable.

This equipment can be installed wherever is most convenient, adjacent to the operating room, and is said to have no damaging effect upon operating room instruments.

Sterile Bacilli Fight Infection

Coli-Bactragen is the name of a new product for the prevention of peritonitis introduced to the hospital and medical world by the American Hospital Supply Corporation, Merchandise Mart, Chicago. The company reports that "Coli-Bactragen consists of sterile Colon Bacilli of B-Coli suspended in gum tragacanth. It is introduced into the peritoneal cavity immediately before or during the surgical procedure. The sterile bacteria induce a high concentration of phagocytic cells at the point of possible infection while the gum tragacanth serves to localize the injection at the endangered area.

"Coli-Bactragen is packed in 30 c.c. rubber stoppered vials from which the liquid is extracted by means of a syringe. While as yet there is no definite basis for offering Coli-Bactragen as a preventive for adhesions, it has been noted that in all cases where Coli-Bactragen was used there have been no adhesions."

Trade Literature

Plans for Food Service.—Feeding patients back to health is an extremely important part of hospital work, so the kitchen engineers of Albert Pick Co., Inc., of Chicago have pondered long on ways and means on planning hospital kitchens and dietetic departments to achieve a high degree of efficiency in operation. The conclusions at which they have arrived after their studies are set forth in an attractive, liberally illustrated brochure entitled "Feeding for Health." The book is divided generally under two headings: modernization of existing facilities and planning new hospital kitchens. No hard and fast rules are laid down but many suggestions are offered and the services of Albert Pick are placed at the disposal of interested persons.

The QUESTION BOX

How much steam
does it take to heat
100 gallons of water?



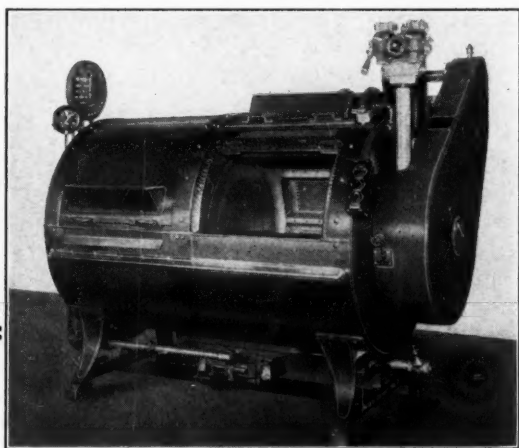
You can find the answer
to this question on page
564 in the new 1937
Modern Hospital Year-

book. Hundreds of other questions about the
performance and maintenance of hospital service
equipment are answered in Armstrong's section
of this book, pages 561-568.

ARMSTRONG MACHINE WORKS
802 Maple Street, Three Rivers, Michigan



**Armstrong Steam Traps for Better
Service and Lower Costs**



**HENRICI—THE NAME THAT
SIGNIFIES HIGH QUALITY, LONG-LIFE WASHERS**

HENRICI

"EFFICIENCY"

Henrici Washers are ideal for
the hospital laundry because
they insure uninterrupted serv-
ice. Built of stainless steel, with
rustless, solderless cylinder and
shell, fewer moving parts and
single end drive, these washers
give greater agitation, silent and
economical washing.

Write for our booklet,
"Henrici Efficiency"

**HENRICI LAUNDRY
MACHINERY CO.**
BOSTON, MASSACHUSETTS
(Mattapan P. O.)

Three Distinct Signals

LIGHTED DOCTOR
DARK IN
FLASHING DOCTOR
OUT
DOCTOR
WANTED

THE HOLTZER- CABOT

In-and-Out Register
system is necessary equip-
ment for every modern
Hospital.

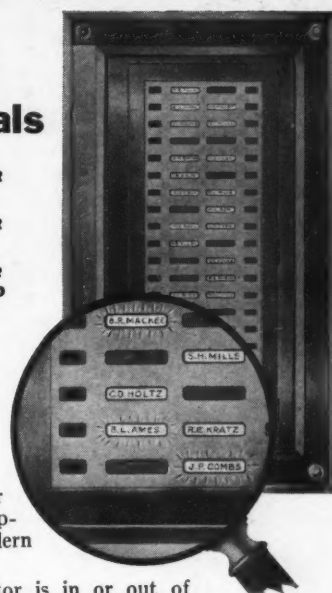
Registers whether doctor is in or out of
building and notifies him when entering or
leaving if wanted at office.

It provides for registration at any number
of entrances, telephone switchboard, superintendent's office,
or any other desired location.

Can be installed at moderate cost and with minimum of
disturbance to patients.

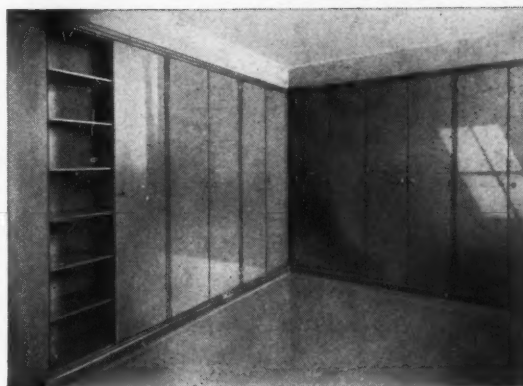
The Holtzer-Cabot Electric Co.

Executive Offices and factory
125 Amory Street **Boston, Mass.**
Branches in principal cities



*Send for
Descriptive
Booklet*

Install KEWAUNEE Casework



*Built-in Storage Cabinets, Taunton State Hospital,
Taunton, Mass.*

We offer the services of the Kewaunee Engineering De-
partment free and without obligation to hospitals planning
on the installation of casework, cabinets, laboratory furni-
ture or diet kitchen equipment. If your institution has a
new building to equip or remodeling to do, it will pay you
to write us at once.

Kewaunee Mfg. Co.
LABORATORY FURNITURE EXPERTS

C. G. Campbell, Pres. and Gen. Mgr.
112 Lincoln St., Kewaunee, Wis.

Eastern Branch: 220 E. 42nd St., New York, N. Y.
Mid-West Office: 1614 Monroe St., Evanston, Ill.

Representatives in Principal Cities



MODERN HOSPITAL WINDOWS *Fenestra*

Fenestra steel windows are peculiarly suited to meet the exacting requirements of this state sanatorium at Howell, Michigan, where light and air are so vital to the welfare and cheerfulness of patients.

Narrow steel frames and muntins permit large glass areas; admit abundant light. Easily operated, projecting ventilators permit controlled ventilation without draft; close tight against inclement weather.

Other advantages include: efficient screening; economical washing from the inside; low initial cost; reduced maintenance. Details sent on request. Detroit Steel Products Company, 2256 East Grand Blvd., Detroit, Michigan.

One Picture Is Worth a Thousand Words.—Photographs of the human interior aren't exactly glamorous but they are of great importance in the study and advancement of medicine. Davis & Geck, Inc., 217 Duffield Street, Brooklyn, N. Y., inform us that they have added more than a dozen new films to their library of surgical motion pictures which are available, without charge except for return postage and insurance fees, to hospitals, medical societies and other professional organizations. A complete list of these films may be obtained by writing to Davis & Geck's Department of Professional Service.

Some Like It Hot—Some Like It Cold.—Icicles dripping on the first page of the little pamphlet recently issued by the Stopperless Water Bottle Co., Chicopee, Mass., announce the new Frez-It pak. The pak (that's the way they spell it) is made of gum rubber, hermetically sealed. Three paks come in a rubber container, in which the manufacturers recommend they be kept while freezing. When freed from the ice chamber, the pak or paks can be taken out as needed. By a quick bending in the hands, the ice inside is broken up to give the necessary flexibility to fit the part of the body on which it is to be placed. The pamphlet also informs us that the pak is equally effective as a heating pad when submerged in boiling water until the desired temperature is reached.

Simultaneously with the announcement of the Frez-It pak, comes a descriptive folder on the Stopper-Tite hot water bottle to which the stopper, made of the same material as the bottle is permanently attached. This precludes the possibility of the loss or hardening of the gasket with its consequent leakings and annoyances. If you are interested in knowing more about these items, the pamphlets will be sent you on request.

A Serial on Cereals.—Under the awe inspiring title of "Summary of a Group of Experiments Comparing the Caloric and Energy Values of Four Well Known Cereals as Prepared for Infant Feeding," Libby, McNeill and Libby, Chicago manufacturers of food products, present study No. 7 of their series on protective nutrition. The pamphlet discusses the results of four experiments which were carried out to compare the energy and fuel values of Libby's cereal combination with three other cereals commonly prescribed for infant feeding. It should make interesting reading for dietitians and pediatricians.

A New Kitchen Catalogue.—Another well known contributor of ideas and equipment to solve feeding problems is Standard Gas Equipment Corporation, 18 East Forty-First Street, New York City, manufacturers of Vulcan gas cooking equipment. Of course, the heavy duty all hot top ranges are the most important items, but Catalog Number 54, resplendent in yellow and orange cover, also presents a wide variety of broilers, bake ovens, short order cookers and such to meet just about every cooking need. One very interesting item is a diet kitchen range, which looks more like a neat kitchen cabinet, especially suitable for the hospital because, they say, it provides large cooking capacity in small space and does a variety of cooking operations.

Reflections on Paint.—Let's consider the illuminating powers of paint. Paint that decorates only is not enough in the opinion of the National Chemical & Mfg. Co., 3617 South Wall Street, Chicago, it must also have high light reflective qualities. In "Painting for Light and Decoration," a recently published exposition on the virtues of Luminall paints, this opinion is enlarged upon and facts and illustrations given to back it up. From the decorating angle, Luminall is said to be odorless, to dry in forty minutes and to require only one coat to cover any surface—no matter what the former color may have been.